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UNIVERSITY OF CAPE TOWN: LAW FACULTY



UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA • UNIVERSITEIT VAN KAAPSTAD

LLM IN COMMERCIAL LAW 2013

DENNIS CHAMISA

CHMDEN001

TITLE: The potential of alternative dispute resolution mechanisms in tackling the increase of lawsuits due to medical negligence in public hospitals

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30 September 2013

Plagiarism

Research dissertation presented for the approval of senate in fulfillment of part of the requirements for the degree of Masters in Commercial Law in approved courses and minor dissertation. The other part of the requirements for this qualification was the completion of a programme of courses.

I Hereby Declare that I have read and understood the regulations governing the submission of Master of Laws dissertations, including those relating to length and plagiarism, as contained in the rules of the University and that this dissertation conforms to those regulations.

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ACKNOWLEDGEMENT

I want to thank my God for the gift of life since my arrival on earth planet to this present day.

The completion of this dissertation, within the shortest time, could not have been realized by me alone without help. It is consequently befitting to acknowledge people in different capacities for their involvement in the completion of this dissertation. Immerse thankfulness goes to my supervisor Professor Allan Rycroft, for his unconditional guidance in my dissertation. I can therefore confirm, in unequivocal terms that this is an end-product of his encouragement, invaluable advice, professionalism and the confidence he had in me. This has also resulted in me 'tapping' from his reservoir of knowledge and experience. I shall always be indebted.

I would also want to acknowledge the research librarians for University of Cape Town, Law Faculty, Dilshaad Brey and Nuroo Davids for their assistance. Furthermore, appreciation also goes to my friend Barbara Kolbeck, for her assistance in editing of this dissertation.

I would also want to extend gratefulness to my parents Dr Edward Elae Chamisa and Mrs Shylet Chamisa for their love and sacrifices. Appreciation also goes to my siblings Sam Chamisa and Samatha Chamisa for their continuous support over the past months. This is not to the exclusion of Lister Samanyanga and Melissa Mhembere for their support and understanding. To my late mother Alice Jnr Samanyanga, the memories of her love and guidance remain a source of inspiration.

I would also want to thank my special friend and dearest Refilwe Lerato Sebothoma, for her support and encouragement during this demanding period.

TABLE OF CONTENT

ACKNOWLEDGEMENT	1
INTRODUCTION	1
WHAT IS ALTERNATIVE DISPUTE RESOLUTION (ADR)?	2
WHAT IS MEDICAL NEGLIGENCE?	2
CHAPTER 1: THE CURRENT LITIGATION SYSTEM	4
INTRODUCTION	4
SPECIFIED SEVEN PROVINCES: SOUTH AFRICA	6
FACTORS FOR THE INCREASE IN MEDICAL NEGLIGENCE	10
i. <i>Shortage of staff and unfavorable working conditions:</i>	10
i. <i>Contingency driven litigation</i>	12
ii. <i>Public's awareness of their rights</i>	13
iii. <i>Effect of the National Health Insurance</i>	15
iv. <i>Relocation from Road Accident Fund to medical negligence</i>	15
v. <i>Is the Legal Aid Available?</i>	15
EFFECT OF MEDICAL NEGLIGENT LITIGATION	16
COMMON MEDICAL NEGLIGENCE CLAIMS INSTITUTED	18
THE NATURE OF LITIGATION	19
<i>Time spent in litigation</i>	21
COMPENSATION NEUROSIS	23
CHAPTER 2: WHAT MAKES MEDICAL CASES COMPLEX?	25
INTRODUCTION	25
FAULT	26
MEDICAL NEGLIGENCE	26
MEANING OF MEDICAL NEGLIGENCE	27
MEDICAL NEGLIGENCE TEST	27
TEST OF REASONABLENESS	29

THE LEGAL CONCEPT OF DUTY OF CARE.....	30
BURDEN OF PROOF	32
EXEMPTION CLAUSE.....	33
VICARIOUS LIABILITY	36
CAUSES OF MEDICAL NEGLIGENCE	37
<i>Misdiagnosis</i>	37
<i>Childbirth Injuries and death</i>	38
<i>Anesthesia Errors</i>	39
<i>Medication or Prescription errors</i>	39
<i>Incompetence and shortage of staff</i>	40
<i>Shortage of facilities/ substandard medical care</i>	41
ANALYSIS OF CERTAIN MEDICAL NEGLIGENCE CASES.....	41
CHAPTER 3: ALTERNATIVE DISPUTE RESOLUTION MECHANISMS AND MANDATORY MEDIATION	
RULES.....	45
INTRODUCTION	45
DESCRIPTION OF ALTERNATIVE DISPUTE RESOLUTION	45
THE ETHICAL ISSUES ARISING IN ADR.....	46
ROLE OF LAWYERS IN ADR MECHANISMS.....	48
NEGOTIATION.....	49
<i>Limitations of negotiation as a technique</i>	51
ARBITRATION.....	51
<i>Benefits of medical negligence arbitration</i>	52
<i>Limitations of arbitration as a technique</i>	53
MEDIATION.....	54
MANDATORY MEDIATION RULES.....	54
WHY MEDIATION IS PREFERABLE	56
UBUNTU AND MEDIATION.....	63
<i>Limitations of mediation</i>	64

CHAPTER 4: HOW TO MAKE MEDIATION EFFECTIVE.....	68
INTRODUCTION	68
STRATEGIES FOR MEDIATION	68
<i>Appointment of the mediator</i>	68
<i>Adversarial and interest based strategies</i>	69
<i>Focus on interests and not positions</i>	69
<i>Communication</i>	70
<i>Persuasive</i>	71
<i>Cooperation</i>	71
<i>Multiparty negotiation skills</i>	71
<i>Suspension of court proceedings</i>	72
<i>Voluntariness</i>	72
CHAPTER 5: COMPARATIVE ANALYSIS OF USA AND SA MEDIATION SYSTEMS	74
INTRODUCTION	74
COURT ANNEXED ARBITRATION.....	75
COURT ANNEXED MEDIATION.....	79
<i>Case Study of the state of Florida State</i>	81
<i>Case Study of the state of Texas</i>	82
MEDIATION PROCESS: USA AND SA.....	87
<i>Confidentiality and Non-disclosure privilege</i>	87
<i>Impartiality and neutrality</i>	88
<i>Voluntariness</i>	88
<i>Mediator's role</i>	88
<i>Termination of the mediation process</i>	89
<i>Caucuses</i>	89
<i>Settlement Agreement</i>	90
MODELS OF MEDIATION IN US AND SA	91
CHAPTER 6: CONCLUDING OVERVIEW	94
FINDINGS.....	95

RECOMMENDATIONS	96
<i>Mediation Panel Composition</i>	96
<i>Independent body</i>	96
<i>Introduction of cap system for the cost of negligence</i>	97
<i>Training of mediators</i>	97
<i>IT and Mediation</i>	97
<i>Syllabus change for medical students</i>	97
BIBLIOGRAPHY	99
ANNEXURE I	113
CODE OF CONDUCT FOR COMMISSIONERS	113

University of Cape Town

LIST OF FIGURES

FIGURE 1: MEDICAL PROTECTION SOCIETY (MPS) DATA	5
FIGURE 2: SPECIFIED SEVEN PROVINCES: SOUTH AFRICA	6
FIGURE 3: MEDICAL NEGLIGENCE: GAUTENG PROVINCE CLAIMS FOR 2012.....	8
FIGURE 4: SHORTAGE OF STAFF AND UNFAVORABLE WORKING CONDITIONS	10
FIGURE 5: COMMON MEDICAL NEGLIGENCE CLAIMS INSTITUTED.....	18

University of Cape Town

INTRODUCTION

One of the most pervasive problems facing the South African Health Department is the increase of medical negligence in public hospitals as alleged by the various newspapers.¹ There has also been a corresponding increase in medical negligence lawsuits. However, it is widely acknowledged that determining issues of causation and fault in medical cases is often a complex, lengthy and expensive process.² This inevitably results in a huge backlog of medical lawsuits, a development suggestive of the ineffectiveness of the formal litigation system in South Africa. This dissertation explores whether, in the light of the increase of lawsuits, alternative dispute resolution (ADR) mechanisms offer better, expeditious, and cost efficient channels of resolving medical negligence lawsuits than formal litigation.

There are factors that make formal litigation less desirable for redressing medical negligence claims. One is that the evidentiary requirements for proving medical negligence, such as the causative link between treatment and injury, are rigid. Second, the passage of time, is prone to occur in most lawsuits, may leave the victims' memory rusty, making it difficult for him/her to provide reliable information. Third, a successful litigant may be denied immediate access to the fruits of litigation by appeals. Lastly, there is the problem of uncertainty that attends to litigation in an adversarial context, if a plaintiff institutes an action for damages on several grounds; the chances of succeeding on all grounds are slender. This dissertation argues the position that the difficulties that attend to litigating medical negligence can be constricted by the use of Alternative Dispute Resolution (ADR).

From a public policy point of view also, ADR ought to be preferred to litigation. Litigation imposes heavy resource³ burdens on the State. The strain is avoidable in an ADR system; huge legal costs and a judicially awarded compensation are avoided, while an agreeable settlement can be negotiated between the parties. Ameliorating these burdens on the State is one of the main thrusts of this

¹ This will be demonstrated by the number of reported medical negligence cases in public hospitals by various newspapers articles.

² D Dinnie *Increasing medical malpractice claims* (2012).

³ Resource refers to "finance and human means".

dissertation. Therefore, the dissertation shall argue for the use of ADR as the possible solution to the problem of medical lawsuits in public hospitals.

What is Alternative Dispute Resolution (ADR)?

Alternative Dispute Resolution (ADR) refers to procedures used for settling disputes other than by means of litigation, which are usually less costly and more expeditious than medical negligence litigation procedure.⁴ The use of ADR would also ensure that disputes are resolved more privately compared to litigation.⁵ Examples of ADR techniques are negotiation, mediation and arbitration. The proposition of this dissertation is that ADR should be used as a normative option by parties in tackling medical negligence disputes, because ADR offers the tailoring of process to fit the nature of the dispute. In addition, ADR also offers arbitration as an appropriate modification of the standard arbitration.⁶

What is medical negligence?

According to Loubser, the concept of negligence involves the appraisal of the defendant's conduct according to a standard that is acceptable to society.⁷ However, medical negligence is measured against a standard of care and proficiency recognized by a narrower society, namely the medical profession. Claasen argues that negligence refers to both the prohibitory substance and the requirement of fault, which should be equally applied to the medical society.⁸ Teff propounds that there is no rational justification for regarding medical negligence as somehow conceptually different from negligence in general.⁹ In the case of *Weber v Santam Versekeringsmaatskappy Bpk*¹⁰ it was stated that if the defendant's conduct does not fit into the standard of a reasonable person, such behavior will be blameworthy in law and the defendant will be considered to be at fault. In *Kovalsky v Krige*¹¹ it was

⁴ SJ Ware *Alternative Dispute Resolution* (2001).

⁵ SB Meek *Alternative Dispute Resolution* (1996).

⁶ Ware op cit note at 4.

⁷ MM Loubser *The Law of Delict in South Africa* (2010).

⁸ NJB Claasen and T Verschoor *Medical Negligence in South Africa* (1992) at p.5.

⁹ H Teff *Reasonable care: Legal Perspectives on the Doctor-Patient relationship* (Oxford: Clarendon Press) 1994 at p.175.

¹⁰ *Weber v Santam Versekeringsmaatskappy Bpk* 1983 (1) SA 381 (A) 410-411.

¹¹ *Kovalsky v Krige* (1910) 20 CTR 822.

held that a medical practitioner, like any professional man, is required to use a reasonable amount of skill and care. Failure to exercise such skill and care required of a reasonable person in the position of the doctor renders the doctor liable for damages. This dissertation shall argue the position that negligence test of a reasonable doctor would be used as a yardstick to medical negligence in public hospitals.¹² Henceforth, medical malpractice is a negligent act or omission by a medical professional that results in personal injury to a patient.¹³

University of Cape Town

¹² It is to be noted that medical negligence shall be discussed in detail in Chapter 2.

¹³ Ibid at 619.

CHAPTER 1: THE CURRENT LITIGATION SYSTEM

Introduction

The dissertation shall analyze medical negligence claims in seven selected provinces in South Africa, between 2008 and 2009. In this period the Northern Cape and Mpumalanga recorded the highest of amassed claims accumulating to R23 million and R20 million respectively. Such figures are indicative of inevitable torpedo in medical negligence claims for the Department of Health. The dissertation shall also look at Gauteng province for 2012, recording the most recent report of medical negligence claims. In this chapter, the dissertation shall look at various factors prompting the increase in medical negligence claims and common medical negligence claims instituted in litigation. This shall be juxtaposed with a discussion of the nature of the litigation; time spent and legal costs incurred in the process; and the abuse of compensation neurosis in the litigation system.

The escalation in medical claims¹⁴

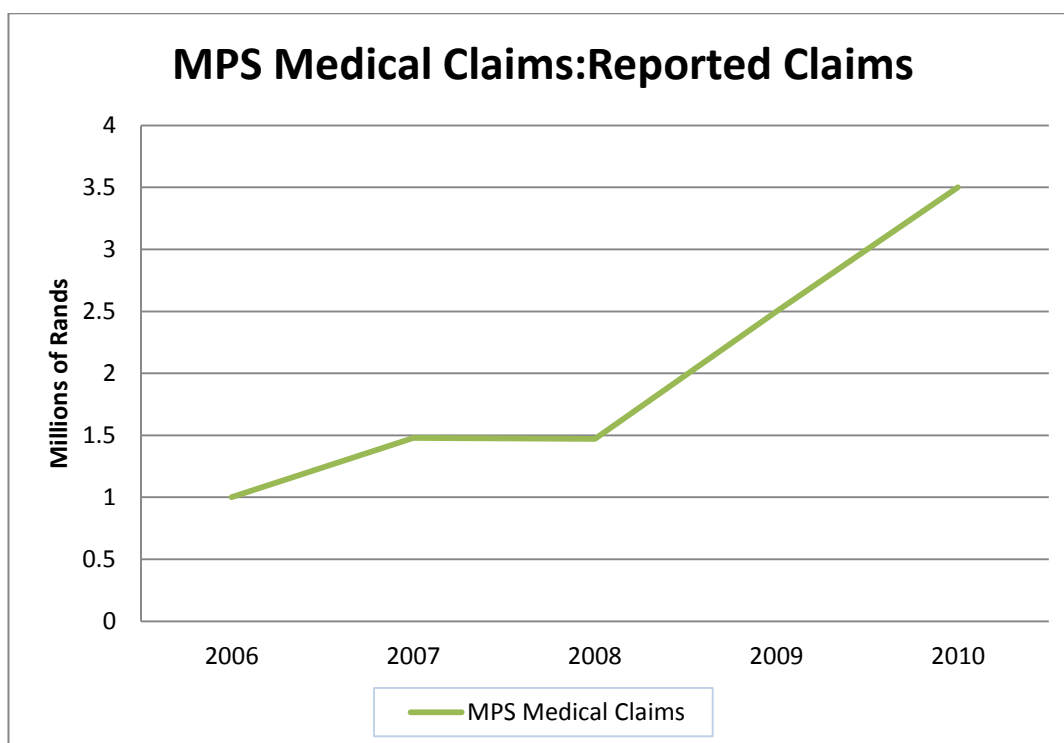


Figure 1: Medical Protection Society (MPS) data

Medical Protection Society (MPS) data in Fig 1 shows a gradual increase between 2006 and 2007. However, from 2008 to 2010 there is an upward trend of medical negligence claims in South Africa. This suggests that the up-ward curve is indicative of the intensification of claims. One of the contributory factors to such an increase is the combined effect of literate patients who are becoming better informed of their rights and the medical law litigators who are becoming aggressive. The commission or omission of medical negligence by medical practitioners in public hospitals has created opportunities for medical negligence litigators who have shifted focus from litigation with the Road Accident Fund (RAF) to medical practice, with uncapped compensation. The intensification of medical lawsuits has resulted in a clogging of the legal system; this deprives the Department of Health of its capacity deliver other services as an increasing percentage of its resources will be diverted to settle medical negligence claims.

¹⁴ Source: C Bateman 'Medical negligence pay-outs soar by 132%': *South African Medical Journal* (SAMJ); Vol 101, No 4 (2011), available at <http://www.samj.org.za/index.php/samj/article>: (accessed 01 April 2013): Due to challenges encountered in securing medical negligence data in public hospitals at national level, the dissertation has relied on various published newspaper articles.

Specified seven provinces: South Africa¹⁵

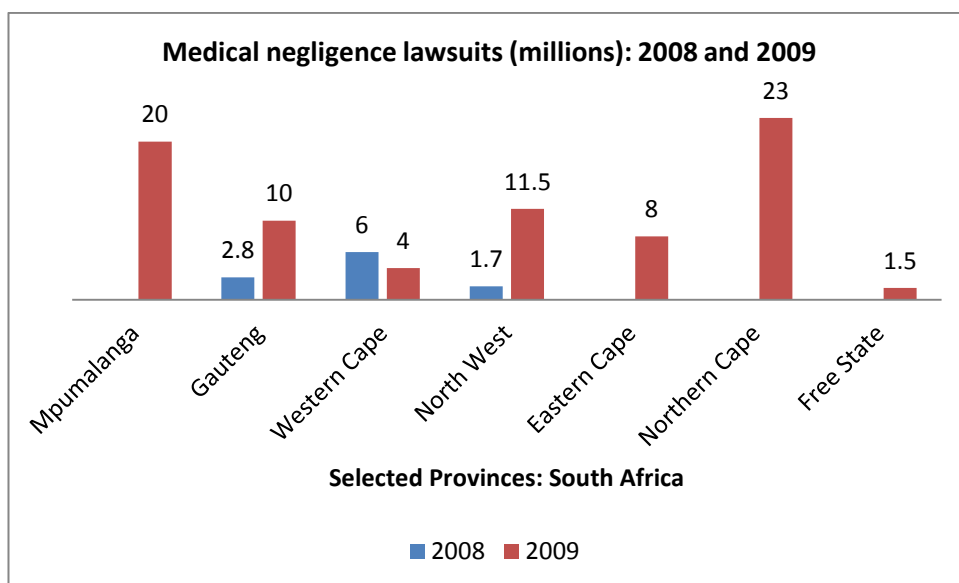


Figure 2: Specified seven provinces: South Africa¹⁶

Fig 2 shows recorded medical negligence claims of selected seven provinces. These seven provinces are Mpumalanga, Gauteng, Western Cape, Northern Cape, North West, Free State and Eastern Cape. It is a suggestion of this dissertation that these provincial statistics are ‘microcosm of the macrocosm’ of lawsuits that have been instituted against public hospitals in South Africa nationally. It should be noted that the data for Mpumalanga and Free State constitute aggregated figures for 2008 and 2009 respectively.

As shown in Fig 2 the increase in medical negligence between 2008 and 2009 is indicative of the upward trends in public hospitals for Gauteng, and North West, except for Western Cape which has a decline. For the period of 2008 and 2009 Mpumalanga has one of the highest lawsuits for medical negligence, at R20 million. Comparison between Mpumalanga and Free State demonstrates that the figures are even higher than the 2008 and 2009 aggregated figures for Free State, which accumulates to approximately R1.5 million. The highest lawsuit recorded for the period in question is for Northern Cape, with R23 million for 2009. The statistics

¹⁵ Source: E Naidoo ‘Our disastrous Doctors; Sunday Tribune, 02 May 2010.

¹⁶ Due to challenges encountered in securing medical negligence data in public hospitals at national level, the dissertation has relied on various published newspaper articles statistics.

reveal the extent to which medical negligence is becoming a threat to the existence of the Department of Health in South Africa. For instance the provincial budget for the Gauteng for 2009/2010 was R55 259 million and the budget for 2010/2011 was R55 915 million.¹⁷ In which the Gauteng Health Department tackled malpractice claims totalling R573 million from 2009 to 2010, according to its annual report.¹⁸ The Eastern Cape Health Department paid out R43 million in legal settlements in 2010 which is more than three times the amount paid out in 2011.¹⁹ This resulted in the provincial Eastern Cape Department of Health receiving adjusted Budget of 11,773,927 for the 2009/2010 period after exhausting its allocated budget for the year.²⁰

In 2009 Eastern Cape, incurred R8 million for claims; previously it paid out R43 million for compensation.²¹ The Eastern Cape Department of Health is still defending 269 cases of medical negligence which is inclusive of cases back dating to a period prior to 2002.²² Although it was ordered to pay out R159 million in legal liabilities for medical negligence²³ but no disciplinary action was taken against the negligent workers for such cases.²⁴ It is argued that this encourages delinquency with impunity. In 2009 it was reported that about 200 lawsuits were pending against the Eastern Cape Health Department, some dating back 2005.²⁵ The question is whether such 200 claims should be regarded as acceptable risk for the Eastern Cape Department of Health? Due to these negligent increases it is submitted that the public

¹⁷ Gauteng Department of Health Report of the Integrated Support Team, (2009).

¹⁸ MPS, Malpractice claims cost Gauteng R573 million 10 March 2011, available at <http://www.medicalprotection.org/southafrica/latest-news/malpractice-claims-cost-gauteng-r573-million>, (accessed 18 August 2013).

¹⁹ MPS, Eastern Cape Department of Health pays out R43 million in legal settlements, 11 July 2012, available at <http://www.medicalprotection.org/southafrica/latest-news/dh-pays-out-r43-million-in-legal-settlements>, (accessed 18 August 2012).

²⁰ Eastern Cape Department of Health Report Annual Report 2009/2010, available at http://www.ecdoh.gov.za/ecdoh/reports_and_publications/294/Annual_Report, (accessed 18 August 2013).

²¹ Eastern Cape Health Department; REPORT OF THE AUDIT COMMITTEE FOR THE YEAR ENDED 31 MARCH 2008, available at <http://www.ecdoh.gov.za>, (accessed 18 April 2013).

²² Eastern Cape Department of Health pays out R43 million in legal settlements, 11 Jul 2012; <http://www.medicalprotection.org/southafrica>, (accessed 18 April 2013).

²³ LA Butler 'Medical Negligence costing province's health department millions' The Herald, 20 November 2009.

²⁴ Butler op cit note 23.

hospitals are becoming “*death ploy*” for the poor who cannot afford alternative health care, which similarly burden the ineffective adversary system with voluminous cases. It is uncontroversial that the current litigation system has contributed to the total costs paid for medical negligence claims.

Medical Negligence Gauteng Province claims for 2012²⁶

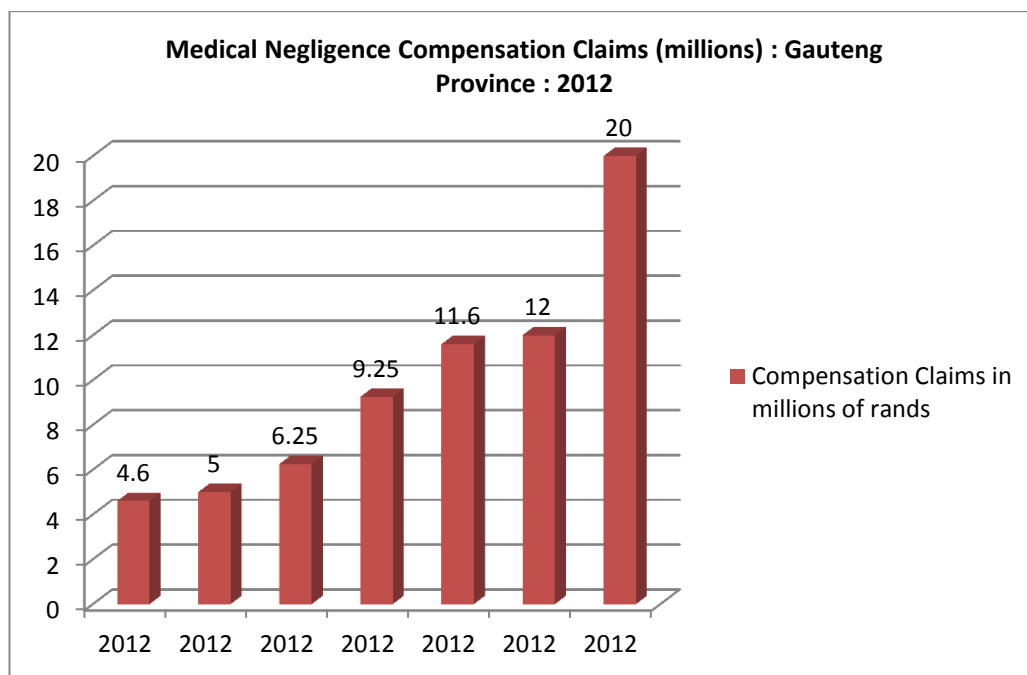


Figure 3: Medical Negligence: Gauteng Province claims for 2012²⁷

As indicated by Fig 3 medical negligence settlements granted in 2012 for Gauteng reveals lucidly that there is disproportional increase in medical negligence claims. The arithmetical figures in Fig 3 shows compensation claim cases that amount to approximately R70 million as an aggregate figure, incurred by Gauteng Department of Health. Besides the settled claims which run up to millions in 2012 one must focus on the pending payouts of R1.4 billion negligence claims which are still to be brought in the South African courts for litigation. Although Gauteng province is the most populous province, Fig 3 shows that the province is becoming the epicenter of medical negligence. This is prompted by the surge in ‘compensation

²⁶ J Bloom ANOTHER HUGE MEDICAL NEGLIGENCE AWARD IN GAUTENG posted 9 October 2012, <http://www.dampl.co.za> (accessed 31 March 2013).

²⁷ Due to challenges encountered in securing medical negligence data in public hospitals at national level, the dissertation has relied on various published newspaper articles statistics.

cost figure' of such selected cases in Gauteng, which echoes the inescapable macrocosm reality that submerge the litigation system.

According to a SABC documentary produced by Amos Phogo in 2012 the Gauteng government paid more than R52 million prior to 2012 for litigation cases due to medical negligence in public hospitals. The total costs incurred by the Gauteng Health Department exceeds such R52 million mark, as it was also facing overwhelming unresolved litigation claims amounting R800 million.²⁸ It is clear that the Court system faces a challenge in tackling the increase in medical negligence lawsuits. This can be demonstrated by number of cases the judges hear per day. For instance the South Gauteng High Court civil roll call has 73 cases before the Honourable Judge Mojapelo DJP with case numbers going down to 2005.²⁹

On the other hand, Gauteng Health Department is strained financially due to the impact of medical negligence.³⁰ It was reported that due to available limited resources the ability of the public of health to function is now becoming extreme owing to the increase in the number of medical negligence.³¹ It also stated that the court attached the assets for the court order to pay for medical negligence.³² Most if not all of the contested cases have been lost,³³ thus plus the costly nature of the litigation system, this means the Department of Health has been penalized with costs orders in such cases as the losing party. The dissertation contends that the Department of Health and State Attorney's office have unjustifiable craving to defend each and every summons without considering its merits. This is supported by

²⁸ A Phago Collateral Damage: The Khanyi family have had terrible experiences with the public healthcare system; (SABC) Special Assignment, 29 November 2012.

²⁹ SOUTH GAUTENG HIGH COURT (JOHANNESBURG) WEDNESDAY 21 AUGUST 2013, CIVIL TRIAL ROLL CALL BEFORE THE HONOURABLE JUDGE MOJAPELO DJP AT 9:30 IN COURT GC, available on http://www.johannesburgbar.co.za/daily_roll/CivilTrialRoll, (accessed 18 August 2013).

³⁰ J Malherbe Counting the cost: The consequences of increased medical malpractice litigation in South Africa (2012) 103 *South African Med Journal*.

³¹ Ibid at 25.

³² City Press Newspaper, "Gauteng health dept. faces seizure of assets for negligence," available on <http://www.citypress.co.za/news/gauteng-health-dept-faces-seizure-of-assets-for-negligence>, (accessed on 16 August 2013).

³³ O Mooki Negligent Gauteng Health Department to pay, 13 November 2012, available on <http://www.iol.co.za/news/crime-courts/negligent-gauteng-health-department-to-pay>, (accessed 16 August 2013), Jack Bloom, for Democratic Alliance (DA) is quoted saying that the Gauteng Department of Health has lost every single court case brought against it.

Bloom, who argues that the Gauteng Health Department should try to settle many of its cases out of court to avoid high cost that comes with defending bad cases.³⁴

Factors for the increase in medical negligence

How does one account for the increase in medical malpractice claims and damages awarded over the past few years? Dinnie addresses many pertinent causes to the increase in medical negligence such as the increased sophistication of the patient base and preparedness by attorneys to litigate such cases on a contingency basis.³⁵ There are also a number of factors which contribute to the increase in medical negligence litigation such as unfavorable working conditions.³⁶ Dinnie does not indicate the litigation costs and period taken from the time summons are issued to the time judgment is granted in medical negligence litigation.

i. Shortage of staff and unfavorable working conditions:³⁷

	Hospital Budget	Staff per Beds	Total Staff Budget
CHB	R922m	1.6 (SE =1.92)	4690
Tertiary Hospital B	R875	2.91(SE = 3.08)	3500
Hospital C	R240	1.85 (SE=1.9)	1450
Hospital D	R214	1.71 (SE=2)	1340
Hospital E	R454	2.8 (SE=3.3)	2660
Hospital F	R115	2.4	850
Hospital G	R120	2.16(SE=2.5)	817
Hospital H	325	1.9 (SE=2.39)	1649

Figure 4: Shortage of staff and unfavorable working conditions

³⁴ Bloom op cit note 26. Bloom J is a Member of Parliament for Democratic Alliance (DA) of which he is the spokesperson for Health.

³⁵ Dinnie op cit note 2

³⁶ N Slabbert and M Pepper 'Is South Africa on the verge of a medical malpractice litigation storm?' (2011) 4:1 *SAJBL*.

³⁷ K von Holdt and M Murphy *Public hospitals in South Africa: Stressed institutions, disempowered management* in *Management of public hospitals in South Africa* (2006).

This data in Fig 4 is compared to USA public hospitals, nursing staff in metropolitan and rural hospitals, in which USA metropolitan, has the lowest patients to nurses' ratio of (0.8 patients per nurse) whereas rural has (1.7 patients per nurse).³⁸ The data are indicative of a number of staff per bed, and how various public hospitals are strained of financial resources, which cripple their capacity to discharge duties. Fig 4 shows South African public hospitals have more beds compared to staff. The South African staff per bed ratio is more than the proportion for USA.

The shortage of staff in public hospitals contributes to the increase of medical negligence.³⁹ Karl von Holdt, writing in 2006, confirmed that most of the public hospitals are under pressure due to shortage of staff, unmanageable workloads and the failures by the management.⁴⁰ Due to this disproportional ratio doctors and nurses are over-strained and left exhausted.⁴¹ Workload and differential allocation of resources in public hospitals are the primary cause of stress.⁴² Fig 4, demonstrates how the shortage of staff results in medical practitioners carrying a workload that is unbearable. This triggers medical negligence cases that could be avoided in public hospitals. The table in Fig 4 also shows CHB⁴³ as highly stressed as far as the numbers of staff per beds are concerned.

According to Pearmain and Carstens, the shortage of medical services and qualified health care practitioners (inclusive of doctors, nurses and paramedics) has compromised the provision of quality health care,⁴⁴ in that those not qualified are often given tasks for which they have no knowledge, and of which they lack the skills to discharge. This tendency is reported to be frequent in rural hospitals.⁴⁵

³⁸ T Frazee Public Hospitals in the United States, 2008, *Statistical brief* No 95, September (2010) at 2, available at www.hcup-us.ahrq.gov/reports/statbriefs/sb95.pdf, (accessed 19 August 2013).

³⁹ von Holdt and Murphy *ibid* 37.

⁴⁰ Commission of Inquiry 1999.

⁴¹ von Holdt and Murphy *op cit* note; Commission of Inquiry *op cit* note 40.

⁴² *Op cit* at page 17.

⁴³ CHB is a formerly black hospital, while Hospital B is a formerly white institution.

⁴⁴ Pearmain and Carstens *op cit* note 13.

⁴⁵ Pearmain and Carstens *op cit* note at 623.

Hence, increase in medical negligence is triggered by intolerable working conditions in hospitals.⁴⁶

Highly relevant in stressed hospitals is what has come to be known as ‘The invisible gorilla test’ which assesses unintentional blindness.⁴⁷ In terms of Chabris’ research, researchers request participants to complete a primary task (counting passes of the ball) while an unanticipated stimulus (a person wearing a gorilla suit) is presented.⁴⁸ Subsequently, researchers ask participants if they saw anything unusual during the primary task. A majority of people do not notice the gorilla. It is concluded that the failure to see the gorilla is ascribed to the failure to attend to it while engaged in the task of counting the number of passes of the ball.⁴⁹ The finding reveals that a person’s mental workload can interfere with ability to process other stimuli.⁵⁰ Hence, when a person’s attention is invested fully on one stimulus he/she will focus less on the other stimulus.⁵¹ This supports the dissertation’s contention that medical practitioners’ capacity is affected by fatigue and diminished concentration, which instigates medical negligence.⁵²

i. Contingency driven litigation

Most attorneys are now prepared to litigate medical negligence cases based on the contingency-fee basis. The poor, because there is no need to finance the litigation, are afforded the same opportunity as wealthy litigants to institute legal action for malpractice in various public hospitals. In terms of section 3 (1) to (3) the Contingency Fees Act⁵³ a legal practitioner and their clients can conclude a contingency fees agreement. Hence, both the attorneys and advocates are permitted to accept litigation work on the condition that no fee will be charged if the supposed litigation is unsuccessful. However, if the litigation is successful, the legal

⁴⁶ D Bass ‘Medical negligence – what is SAMA’s position?’ (2005) 95: 8 *SAMJ*.

⁴⁷ CF Chabris and D Simons *The Invisible gorilla and other ways our intuition deceives us* (2010).

⁴⁸ Ibid at 40.

⁴⁹ Chabris and Simons op cit note 47.

⁵⁰ Op cite note.

⁵¹ SB Most *What's "inattentional" about inattentional blindness? Consciousness and Cognition* (2010).

⁵² CHB Transformation Task Team: *Chris Hani Baragwanath Hospital: Situation Analysis* (2004).

⁵³ CONTINGENCY FEES ACT, 1997.

practitioners will be entitled to a fee up to 100% more than their normal or usual rate,⁵⁴ but may not receive more than 25% of the amount awarded to the client as a result of the litigation.⁵⁵ Medical litigation has been a factor in the increase in South African court cases⁵⁶ due to the contingency fees arrangement in which the legal practitioner undertakes to render services on a 'no win, no fees' basis. The benefits derived from a share of the litigation proceeds by legal practitioners encourage victims of medical negligence to take up the case on litigation against the Department of Health. It is the dissertation's position that this has contributed significantly to the increase of medical negligence claims, instituted against public hospitals in South Africa.

ii. Public's awareness of their rights

The other factor is that the public has become well informed about legal matters in that the increase in awareness of patients' rights corresponds with the increase in medical litigation.⁵⁷ Pepper and Slabbert suggest that South Africa is witnessing a severe increase in medical practice litigation because patients are increasingly becoming aware of their rights.⁵⁸ In addition, Law firms, Legal Aid Clinics, NGO and other rights centers provide legal support mechanisms to assist those embarking in medical negligence litigation.⁵⁹ This clearly strains the capacity of the courts vis-à-vis its failure to exhibit alternative dispute resolution mechanisms to settle medical negligence disputes.⁶⁰

Furthermore, the Consumer Protection Act (CPA)⁶¹ applies to health care service providers in which patients qualify as consumers under the Act. In the context of healthcare, the CPA term 'service' denotes work performed by a person for the direct or indirect benefit of another, including the provision of consultation or

⁵⁴ D Mitchell Contingency fees and justice for all? *May 1998 Consultus*; Cape Bar.

⁵⁵ Mitchell op cit note.

⁵⁶ *Mofokeng v Road Accident Fund* (unreported case no 22649/09); *Makhuvele v Road Accident Fund* (unreported case no 19509/11); *Mokatse v Road Accident Fund* (unreported case no 24932/10); *Komme v Road Accident Fund* (unreported case no 20268/11).

⁵⁷ Dinnie op cit note.

⁵⁸ Slabbert and Pepper op cit note 34.

⁵⁹ D Dinnie *Increasing medical malpractice claims* (2012).

⁶⁰ Ibid.

⁶¹ Consumer Protection Act, 68 of 2008.

medical advice rendered by health practitioner, or any medical intervention, such as an operation. In terms of section 54 (1) (b)⁶² public hospitals are obligated to provide services in a manner and quality the persons are generally entitled to. It is clear that under the Consumer Protection Act⁶³ patients are being given a right to institute lawsuits against anyone in the supply chain.

Pepper and Slabbert⁶⁴ contend the traditional common law obstacle which required proof of negligence is no longer applicable due to article 61 (3) of the Consumer Protection Act.⁶⁵ It is the position of this dissertation that such has created a 'vicious condition' that places an increasingly onerous burden on the health care practitioners, which open a floodgate of medical litigation. In terms of the CPA, medical negligence claims will increase, because under product (medicines) liability the plaintiff has the onus to prove only that the medicines provided were unsafe, defective and instigated the harm.⁶⁶ It is argued that 'no fault liability provision' will allow the claimant to hold hospitals liable for harm and cost with regard to goods or products such as defective prostheses, implants etc.⁶⁷ The CPA is also applicable to the quality of services that are performed in hospitals, in which the patient has the right to a timely service in a manner and quality the patient is entitled to expect.⁶⁸ Hence, surgical operations are also covered under CPA. It is suggested that where there is a conflict between the Consumer Protection Act and other health care legislation such as the Health Professions Act,⁶⁹ the Act offering the greater protection to the consumer will apply without hesitancy.

⁶² Consumer Protection Act, 68 of 2008.

⁶³ Op cite note.

⁶⁴ N Slabbert and M Pepper 'The Consumer Protection Act: No-fault liability of health care providers' (2011) 101:11 *South African Medical Journal*.

⁶⁵ Consumer Protection Act 68 of 2008; Slabbert and Pepper op cit note 64. Attest that no fault provision in this Act will cause an increase in medicolegal litigation. Since the claimant can sue anyone in the supply chain.

⁶⁶ Op cite note.

⁶⁷ Ibid.

⁶⁸ D DINNIE HOSPITALS AND CONSUMER PROTECTION, DENEYS REITZ INC, available on www.insurancegateway.co.za, accessed on 16 August 2013.

⁶⁹ Health Professions Act 56 of 1974.

iii. Effect of the National Health Insurance

The other factor is that if much reliance is maintained on the national health insurance service, it is undoubtedly that the State would be exposed to increased claims due to medical negligence, especially from doctors in high risks specialties.⁷⁰ This will also over-strain the ability of the litigation system in coping with the demand in lawsuits, thus makes ADR mechanisms more desirable before the matter is referred for trial. Some scholars further argue that the detrimental usage of litigation is attributed to uncapped damages.⁷¹

iv. Relocation from Road Accident Fund to medical negligence

The objective of Road Accident Fund⁷² is to pay compensation in accordance with applicable legislations for personal loss or damage wrongfully caused by the driving of a motor vehicle. It is the argument of this dissertation that prior to the Road Accident Fund Act, of 1996, the legal practitioners instituted uncapped claims for compensation against the old Road Accident Fund (RAF) Act in which large amounts were paid even for foreign claimants. However, after the capping system was introduced the legal practitioners repositioned their focus from RAF to medical negligence in public hospitals, as it is still one of the field where claims for compensation can be instituted without being capped.⁷³ This diversion by legal practitioners from RAF to medical negligence has contributed to the increase of lawsuits.⁷⁴

v. Is the Legal Aid Available?

Previously the Legal Aid Board's legal scope excluded medical negligence cases from its mandate. However, there is a change of policy as there is an initiative to start to institute such claims on behalf of the poor in its attempt to provide quality legal services to the poor and vulnerable. An interview with the Cape Town Legal

⁷⁰ Slabbert and Pepper op cit note 36.

⁷¹ Ibid.

⁷² Road Accident Fund Act 56 of 1996 came into operation on the 1 May 1997 (OLD ACT) and The Road Accident Fund Amendment Act, 2005 came into operation on the 1 August 2008.

⁷³ J Seggie The 'boom' in medical malpractice claims patients could be the losers (2013) 103:7 *South African Medical Journal*.

⁷⁴ J Malherbe op cit note 30; malpractice claims have become a boom industry, available at <http://www.citypress.co.za/news/doctors-lose-patience-as-suits-spike-20120707/> (accessed 18 August 2013); Seggie op cit note 73.

Aid Clinic revealed that the body is also starting to institute medical negligence claims on behalf of the indigent.⁷⁵ Hence, there is a widespread increase in medical litigation as the broader population of poor patients will be able to have legal representation to progress with malpractice cases. While access to justice is to be welcomed as a positive development, its impact on the court system needs to be considered.

In addition, it also reported that private companies are being formed to fund civil litigation, in return for a share of settlement.⁷⁶ For instance the claims instituted by Sterling-Rand amounts to millions of rands of legal fees, if the company wins the case it would take between 30% and 50 % of the profit.⁷⁷ Therefore, the establishment of such civil pressure groups to promote the interest of the individual in medical negligence can also have an impact on the court system.

Effect of medical negligent litigation

In the case of *Minister van Polisie v Ewels*⁷⁸ it was held that that an omission to act might result in delictual liability if there was a duty in law to act reasonably and convictions of society would require such omission to be regarded as unlawful.⁷⁹ However, the position of this dissertation is that as society becomes more litigious there will be an 'inevitable predisposition' for public hospital practitioners to shy away from such medical specialties that are most frequently affected.⁸⁰ It is also argued that the increase in litigation will further deter talented individuals from entering the medical profession and thus deprive the Health Department of essential skills.

⁷⁵ Telephonic Interview with Legal Aid Board, 5th & 6th Floor, Nedbank Building, 85 St George Mall, Cape Town, 8001.

⁷⁶ A Visser Eyebrows raised about lawyers funding legal battles, Business Day, 13 August 2013, available on <http://businessday.newspaperdirect.com/epaper/showarticle.aspx?article> (accessed 18 August 2013; <http://www.legalbrief.co.za/article>, accessed 18 August 2013).

⁷⁷ Beeld report, Dié firmas steun klein eisers teen grotes, Monday 12 August 2013, available on <http://www.beeld.com/nuus/2013-08-12-di-firmas-steun-klein-eisers-teen-grotes>, accessed 18 August 2013.

⁷⁸ *Minister van Polisie v Ewels* 1975 (3) SA 590 (A).

⁷⁹ *Minister van Polisie v Ewels* supra (n78) at 591 H.

⁸⁰ A MacLennan, KB Nelson, G Hankins and M Speer 'Who will deliver our grandchildren? Implications of cerebral palsy litigation' (2005) 294 *JAMA* 1688-1690.

The consequence of increase in medical litigation is that public hospital practitioners will be forced to practice defensively and to take extensive professional insurance to cover potential claims.⁸¹ Medical negligence lawsuits negatively affect medical practitioners in that it results in emotional consequences which have an adverse effect on their work and confidence.⁸²

Anecdotal evidence suggests that costs and associated risk of exposure to claims, endured by medical practitioners due to litigation deters medical practitioners from specializing in high-risk medical fields. Hence, to avoid such an adverse consequence befalling upon public hospitals, the potential of ADR mechanisms should be seriously considered.

According to Naidoo, between April 2008 and March 2009 the Health Professions Council of South Africa (HPCSA) reveals that about 90 doctors in South Africa were found guilty of unprofessional conduct,⁸³ in cases of insufficient care, refusing to treat patients, misdiagnosis and practicing outside of scope of competence.⁸⁴ Given this appalling statistics it is therefore necessary to adopt ADR mechanisms to offload the backlog that is being created by the number of professional negligence. Although publicity and accountability will be essential in curbing malpractice and unprofessional conduct, this can further be strengthened by the use of ADR mechanisms to resolve malpractice dispute and improper conduct.

The charts and graphs in Fig 1 to Fig 3 demonstrate vividly that there has been significant increase in both size and frequency of claims over the past years.⁸⁵ According to Pepper, in South Africa there are no long-term statistics on negligence claims that exist compared to USA.⁸⁶ However, the procedural costs of medical

⁸¹ Medical Protection Society (MPS) (South Africa) 'On the defensive': Case book Series (January) 2011; 19(1), available at <http://www.medicalprotection.org/southafrica/casebook-january-2011/On-the-defensive> (accessed 30 January 2013).

⁸² CD Kerr 'The personal cost of medical litigation' (2004) *Med J Aust.* 181:385.

⁸³ S Naidoo Thousands of doctors 'negligent'. Times Live 6 June 2010, available at <http://www.timeslive.co.za/sundaytimes/article489475.ece/Thousands-of-doctors-negligent> (accessed 30 January 2013).

⁸⁴ Naidoo op cit note at 83.

⁸⁵ C Sherlock *Letter to members of the Medical Protection Society re membership renewal and subscription rates* (2010 and 2011).

⁸⁶ Slabbert and Pepper op cit note.

negligence litigation cannot be ignored, as it has a corresponding financial impact to the operation of the public hospitals.

Common Medical Negligence Claims instituted

<p><u>List of common medical negligence claims</u></p> <ul style="list-style-type: none"> • Amputation of the wrong limb • Botched operation • Faulty-blood transfusions • Treatment delays • Plastic surgery malpractice • Anesthesia accidents • Prescription errors • Misread X-rays/mammograms • Pediatric malpractice • Anesthesia accidents • Prescription errors • Misread X-rays/mammograms • Pediatric malpractice • Dental malpractice • Hospital/Emergency Room negligence • Negligence in diagnosing/treating breast cancer • inappropriate intervention for labour and birth obstetrics and gynaecology
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Figure 5: Common Medical Negligence Claims instituted

The table in Fig 5 above disclosures common medical negligence caused in public hospitals which have equally triggered backlog in lawsuits. The most common types of malpractice relates to hospital negligence, botched operation, misdiagnosis,

anesthesia accidents, obstetrics and gynaecology. However, in various rural public hospitals intervention for labour and birth has resulted in many deaths or preventable disabilities resulting due to medical negligence.⁸⁷

The nature of litigation

The multifaceted and rigid aspects of litigation make it undesirable for usage vis-à-vis ADR mechanisms. Litigation is composed of an application procedure and an action procedure.⁸⁸ The work is considered to be of civil litigious nature, if summons or application is issued, and pleadings and notices are exchanged between parties. Such disputes are subject to taxation by the taxing master.⁸⁹ However, this dissertation shall be confined to action procedure. The South African civil procedure is grounded upon essentially that of England.⁹⁰ The adversary nature of the system requires parties to contest their versions before an impartial judicial officer.⁹¹ Pre-litigation requires parties to determine the kind of action to be taken and the court with the jurisdiction to hear the matter. Prior to institute a lawsuit, the party must have *locus standi*, therefore the right person must sue and have the capacity to litigate.⁹² One of the intricacies of litigation is that parties have to observe religiously the time prescribed by legislation and taking note of the court days and calendar days.⁹³

The litigation process requires parties to exchange documents (pleadings) and through summons the defendant will be called to enter an appearance to defend.⁹⁴ In *Room Hire Co (Pty) Ltd v Jeppe Street Mansions (Pty) Ltd*,⁹⁵ Murray AJP stated that if there is real dispute of fact between the parties on any material question of fact it

⁸⁷ M Mkhabela Hospitals of 'no return', Sowetan Newspaper 01 February 2012, available at <http://www.sowetanlive.co.za/columnists/2012/02/01/hospitals-of-no-return>, (accessed on 18 August 2013).

⁸⁸ S Peté *et al Civil Procedure: A Practical Guide*. 2 ed. Oxford University Press, (2011) at 120 and 142.

⁸⁹ Op cite note 88.

⁹⁰ AB Edwards *The History of South African Law* (1996).

⁹¹ Op cite note.

⁹² Peté *et al* op cit note.

⁹³ TJM Paterson *Eckard's Principles of Civil Procedure in the Magistrates' Court*. 5 ed. Juta, (2010).

⁹⁴ Paterson op cit note 93.

⁹⁵ *Room Hire Co (Pty) Ltd v Jeppe Street Mansions (Pty) Ltd* 1949 (3) SA 1155 (T).

will be necessary to proceed by way of action in order to properly test and challenge the evidence. The litigation process is characterized by complexities that tend to deprive victims of timely justice, when cases are adjourned. The longevity of the litigation procedure is often determined by how the parties are determined in pursuing the case. However, in the process, the defendant can invoke various strategies, such as an exception or an application to strike out, or a special plea, which will further prolong the finalization of the case. The contestation of facts in trial courts regarding medical negligence takes a long time, often involving expert witnesses led by both sides. Such delays can be aggravated by court postponements. The period between the pleading stage and judgment can take years and so deprives victims of quick justice and closure. This means their memory to recall events can be impaired. Moreover litigation has a damaging emotional impact on the relationship between medical practitioners and patients.

Time spent in litigation

Case Name	Summons Date	Judgment Date	Total time spent
<i>Galaletsang Ursula M Kgosiemang v Member of the Executive Council: Department of Health, North West</i> ⁹⁶	Summons: 2011	14 February 2013	2 years
<i>Sonny and Another v Premier, KwaZulu-Natal, and Another</i> ⁹⁷	Summons: 2003	7 August, 2009	6 years
<i>Feza Mbodla v MEC for Health Eastern Cape</i> ⁹⁸	Summons: 2011	13 December 2012.	1 year
<i>Olene Hoffmann v Member of the Executive Council, Department of Health Eastern Cape</i> ⁹⁹	Summons: 2007	9 September 2011	4 years
<i>Nyathi v MEC for Department of Health, Gauteng and Another</i> ¹⁰⁰	Summons: 2005	02 June 2008	3 years
<i>Khanyi, Thembeni Martha v Premier of Gauteng</i> ¹⁰¹	Summons: 2008	18 February 2011	3 years
Average			3 years

Figure 6: Reflection of average time spent: a case study of cases chosen at random

⁹⁶ *Galaletsang Ursula M Kgosiemang v MEC for the Department of Health, North-West Province* (308/2011) [2013] ZANWHC 14 (14 February 2013).

⁹⁷ *Sonny and Another v Premier, KwaZulu Natal, and Another* 2010 (1) SA (KZP) 2010 (1) SA.

⁹⁸ *Feza Mbodla v MEC for Health Eastern Cape Eastern Cape* (2701/11) (2012).

⁹⁹ *Hoffmann v MEC for Department of Health, Eastern Cape and Another* (1037/2007) [2011] ZAECPEHC 39 (9 September 2011).

¹⁰⁰ *Nyathi v Member of the Executive Council for the Department of Health Gauteng and Another* (CCT 19/07) [2008] ZACC 8; 2008 (5) SA 94 (CC); 2008 (9) BCLR 865 (CC) (2 June 2008).

¹⁰¹ *Khanyi obo K v Premier of Gauteng* (29703/08) [2011] ZAGPJHC 30 (18 February 2011).

The analysis of above selected court cases between 2003 and 2013 reveals that the average time spent from the issuing of summons to the date of judgment is 3 years. The total time will exceed 3 years if the judgment is appealed by the aggrieved party. In this court case study, *Sonny and Another v Premier, KwaZulu-Natal, and Another*¹⁰² 6 years were spent in settling the medical negligence dispute. This particular court case reveals the complexities that characterise medical negligence litigation. For instance with regard to foetal abnormality, the case was heard on March 12, 2007; March 13, 2007; March 14, 2007; and March 15, 2007. Thereafter the case was postponed and heard on June 9, 2008; June 10, 2008; June 11, 2008; and June 12, 2008. Thereafter, it was subsequently, deferred to December 1, 2008; December 2, 2008; and postponed also to March 26, 2009 and judgement was granted on August 7, 2009. This case is indicative of the inconvenience that one has to endure in pursuing medical negligence dispute through litigation.

In the case of *Feza Mbodla v MEC for Health Eastern Cape*,¹⁰³ in Fig 6, the minimum time the court can spent on a medical negligence case, if there are no material disputes of fact and postponements. In the South Gauteng High Court concerning medical negligence case involving Nicholaas van Niekerk, at the Charlotte Maxeke Johannesburg Academic Hospital,¹⁰⁴ the trial period was from 2005 to 2012. In addition, in the case involving Ntoko Skhosana at Far East Rand Hospital, the trial period was from 2004 to 2012.¹⁰⁵ This is indicative of the amount of time which parties to the medical negligence dispute will have to spend in resolving their dispute. The parties in litigation process may be compelled by the court system to wait for the court date to be scheduled, the process of testing evidence, cross-examination and can be subject to an appeal. Hence, the use of litigation requires massive resources from both parties involved, therefore an expensive exercise. The amount of time devoted in medical litigation, is emotionally draining and unsympathetic to the long term relationship between parties to the dispute. The wrongdoer would be compelled by the court to pay court costs, mostly

¹⁰² *Sonny and Another v Premier, KwaZulu Natal, and Another* 2010 (1) SA (KZP) 2010 (1) SA.

¹⁰³ *Feza Mbodla v MEC for Health Eastern Cape Eastern Cape* (2701/11) (2012).

¹⁰⁴ O Mooki op cit note 33.

¹⁰⁵ Ibid.

for wasting time of the court. The financial impact of the time spent in medical negligence for both the victim and State shall be scrutinized below.

Compensation neurosis

Compensation neurosis is defined as not a formal diagnosis but unconscious attempt exhibited by people who are thought to be developing symptom or not recovering as expected, in order to profit from financial compensation from insurance claims for injury.¹⁰⁶ Section 7 (2) of the Constitution¹⁰⁷ enshrines that State must respect, protect, promote and fulfil the rights in the Bill of Rights. Section 172 (1) (b) of the Constitution¹⁰⁸, provides for constitutional damages, in that one should be compensated for the violations of constitutional rights. In *SA President v ModderklipBoerdery*¹⁰⁹ it was stated that “there is no reason in principle why ‘appropriate relief’ should not include an award of damages, where such an award is necessary to protect and enforce rights. Such awards are made to compensate persons who have suffered loss as a result of the breach of a statutory right. The question is whether this can be turned into a constitutional issue?”

However, due to the financial benefit victims derive from compensation for medical negligence. Some scholars attest that the recompense may result in victims developing compensation neurosis.¹¹⁰ In this dissertation compensation neurosis is regarded as unconscious attempt exhibited by the victim to retain physical or psychological symptoms of illness, in order to profit from financial compensation from the State.¹¹¹ Although, the victims may legitimately be injured or impaired due to medical negligence, they may be tempted to perpetuate the symptoms and vindicate the sick role to accrue the benefits of compensation.¹¹² This means litigation system is open to abuse, which prompted the increase in medical

¹⁰⁶ HC Modlin ‘Compensation Neurosis’ (1986) 14:3 *Bull Am Acad Psychiatry Law*.

¹⁰⁷ Constitution of the Republic of South Africa Act 108 of 1996.

¹⁰⁸ Op cit note.

¹⁰⁹ *SA President v ModderklipBoerdery* (Pty) Ltd 2005 (5) SA 3 (CC).

¹¹⁰ VE Weighill ‘Compensation neurosis A review of the literature’ (1983) 27:2 *Journal of Psychosomatic Research* 97–104.

¹¹¹ Op cite note.

¹¹² C Herbert and MD Modlin ‘Compensation Neurosis’ (1986)14:3 *Am Acad Psychiatry Law*.

negligence amid the costs and time spent in realizing the justice. However, when equated with the ADR such abuse can be nipped in the bud.

CHAPTER 2: WHAT MAKES MEDICAL CASES COMPLEX?

Introduction

The issue of negligence and medical cases evidence presents a multi-layered matrix in apportioning fault. Accountability is a prerequisite for fault. There are different forms of fault negligence (*culpa*) and intention (*dolus*). Medical malpractice is defined as a negligent act or omission by a medical professional that results in personal injury to a patient. Teff propounds that there is no rational justification for regarding medical negligence as somehow conceptually different from negligence in general.¹¹³ The discourse of this chapter shall be confined to the meaning of medical negligence, the negligence test, as enshrined under the principles of delict.

In this dissertation the focus shall be fault in the form of negligence (*culpa*). Negligence is when a person fails to act as a reasonable man would have done in the same circumstances. Furthermore, the question to be interrogated shall be whether the reasonableness test can be applied as a national standard or there is a shift of standard. Hence, the test for negligence shall be critically analyzed in the context of a doctor operating in a good urban hospital and a doctor operating in a poor rural hospital. Attention will be drawn to the difficulties in proving gross medical negligence, due to distinctiveness of medical disputes with regard to pressure, resources, facilities and emergencies. In addition, the dissertation shall discuss complexities associated with exemption clause signed by patients vis-à-vis gross negligence. Thereafter, the dissertation shall discuss the legal concept of duty of care as bestowed upon the medical practitioners. This will be done by exploring the difficulties encountered in providing evidence through burden of proof requirements. It shall further be necessary to discuss whether the principle of *res ipsa loquitur* can be invoked in medical negligence. In imputing liability of medical practitioners on public hospitals, the principle of vicarious liability shall be analyzed in detail. Lastly, the complexities that make it difficult to prove gross negligence shall be considered by analysis of medical negligence cases.

¹¹³ Teff op cit note 9.

Fault

The probabilities in causation investigation depend on the type of loss involved.¹¹⁴ Fault represents both intent and negligence. Although it is factually problematic to provide evidence on negligence case, in *Hoston v East Berkshire Area Healthy Authority*¹¹⁵ the court stated that medical negligence is often difficult to prove that the defendant's conduct caused loss of a chance of a cure. Everyone has to bear the loss he or she suffers.¹¹⁶ However, the principal loss can be shifted to the person who caused it, if the party who suffered loss is able to establish the defendant acted culpably.¹¹⁷ In South African law, accountability is prerequisite for fault.

In *Weber v Santam Versekeringsmaatskappy Bpk*¹¹⁸ court stated that a person is accountable (capable of being at fault) if (i) he or she is able to distinguish between right and wrong (ii) he or she has the necessary mental ability to act in accordance with that insight. There are different forms of fault negligence (*culpa*) and intention (*dolus*). It is therefore, submitted that it is a challenge establish fault, to determine the medical practitioner's accountability.¹¹⁹ Although apportionment of fault is left to the courts to determine, the lack of uniform standard between rural public hospitals and urban public hospitals makes the assessment of negligence extreme difficult and random exercise.

Medical Negligence

The immediate concern of the dissertation is whether there is a conventional understanding of the principles of medical negligence among physicians in public hospitals. If the answer is in the affirmative, then why is there a surge of medical negligence in public hospitals, which has instilled an increment in lawsuits? However, if the response is in the negative, it is therefore, the apprehension of this theory that public hospitals are recipients and referral of the majority of the patients in South Africa. Greater care should be entrusted upon patients in the discharge of

¹¹⁴ F du Bois Wille's *Principles of South African law* (2007).

¹¹⁵ *Hoston v East Berkshire Area Healthy Authority* (1987) 2 All ER 909.

¹¹⁶ Ibid.

¹¹⁷ du Bois op cit note

¹¹⁸ *Weber v Santam Versekeringsmaatskappy Bpk* 1983 (1) SA 381 (A).

¹¹⁹ M Loubser, R Midgley et al *Law of Delict in South Africa* (2010) at 133.

their professional obligations. In this chapter it shall be imperative to first discuss the meaning of medical negligence and the difficulties encountered in proving the occurrence of such, as depicted by the writings of different scholars.

Meaning of Medical Negligence

Negligence is when a person is blamed for an attitude or conduct of carelessness, thoughtlessness or imprudence due to insufficient attention to his action; in failing to adhere to the standard of care required of him under the circumstances.¹²⁰ According to Boberg, ‘a person is negligent if he did not act as a reasonable man ... would have done in the same circumstances.’¹²¹ It is also stated that the knowledge and acumen of physicians in hospitals must always be imputed to the *bonus paterfamilias* whose foresight is the test of foreseeability.¹²²

Loubser propounds that the concept of negligence involves the appraisal of the defendant’s conduct according to a standard that is acceptable to society.¹²³ Conversely, Claasen, argues that negligence refers to both the prohibitory substance and the requirement of fault.¹²⁴ According to Teff, there is no rational justification for regarding medical negligence as somehow conceptually different from negligence in general.¹²⁵ In terms of *Weber v Santam Versekeringsmaatskappy Bpk*¹²⁶ if the defendant’s conduct does not fit into the standard of a reasonable person, such behavior will be blameworthy in law and defendant will be considered to be at fault. Hence, medical malpractice is defined as a negligent act or omission by a medical professional that results in personal injury to a patient.

Medical Negligence Test

In *Kovalsky v Krige*¹²⁷ it was held that a medical practitioner, like any professional man, is required to bear the reasonable amount of skill and care. Failure

¹²⁰ P Neethling and Visser *Law of Delict* (2006).

¹²¹ PQR Boberg *THE LAW OF DELICT: Volume 1 Aquilian Liability* (1984) at 274.

¹²² Boberg op cit note at 273.

¹²³ Loubser op cit note 7.

¹²⁴ NJB Claasen and T Verschoor *T Medical Negligence in South Africa* (1992) at 5.

¹²⁵ H Teff *Reasonable care: Legal Perspectives on the Doctor-patient relationship* (1994) at 175.

¹²⁶ *Weber v Santam Versekeringsmaatskappy Bpk* 1983 (1) SA 381 (A) 410-411.

¹²⁷ *Kovalsky v Krige* (1910) 20 CTR 822.

to exercise such skill and care required of a reasonable person, one will be liable in damages. In the case of *Hughes v Lord Advocate*¹²⁸ it was stated that liability is imposed on negligence, if the *diligens paterfamilias* would or ought to reasonably have known. Negligence in both our law and English law, hinges upon the degree of foresight of a reasonable person. Hence, the negligence test of a reasonable person would be used as a yardstick for medical negligence in public hospitals.

The test for medical negligence means:

- i) Firstly, that the medical practitioner owe the patient the duty of care.
- ii) Secondly, the medical practitioner breached such a duty of care by failing to provide the standard of medical care required.
- iii) Thirdly, the failure by the medical practitioner caused harm which was both foreseeable and avoidable.

According to *Mitchell v Dixon*¹²⁹ ACJ stated that a medical practitioner is not expected to endure the highest conceivable degree of professional care and skill. However, he or she is bound to employ reasonable care and skill and will be held liable for any detrimental consequence. In *Dale v Hamilton*¹³⁰ the defendant was being sued negligence due to burn caused in the course of X-ray examination. In this case, the medical practitioner had limited training or experience in radiography and the X-ray equipment used was timeworn. The court stated that if the doctor undertakes to do radiographic work, he must exercise such with reasonable degree of care and skill. The court awarded damages for loss of income, pain and suffering and loss of general health on the plaintiff. It is therefore submitted that in public hospitals, medical practitioners fail in many incidents to exercise their general level of knowledge, capacity, diligence and experience as defined and expected of the same professions in their positions.

It is highly complicated and often difficult to prove medical negligence cases. It requires victims of malpractice to prove the elements of negligence to receive compensation. It is argued that it is easy to prove in terms of the law that a duty

¹²⁸ *Hughes v Lord Advocate* (1963) 1 All ER 705.

¹²⁹ *Mitchell v Dixon* 1914 AD 519.

¹³⁰ *Dale v Hamilton* 1924 WLD 184.

existed between doctor-patient relationships, to provide medical care commensurate with the skill of any medical practitioner. However, it is difficult to prove that this duty was breached by the medical practitioner and even problematical to demonstrate that the injury suffered by the patient was due to this breach. In *Van Wyk v Lewis*¹³¹ the court stated that negligence could not be inferred merely from the fact that the accident occurred. It has to be proven by the plaintiff that the defendant was bound to exercise all reasonable care and skill. Therefore, enormous evidence will be required to illustrate the link that damage suffered by the patient was due to the injury caused by the medical practitioner.

Test of reasonableness

The test of reasonableness applied to doctors should be looked at against the operational standards that characterize the hospitals. In that the standard of reasonable doctor in rural hospital, who is deprived of basic utensils should not be the same standard applied to urban doctor with access to everything required for carrying out their obligations. Some scholars attest that there are different value judgments offered to the process of medical care of which the meaning of quality is desired by everyone.¹³² It is submitted that circumstances and factors ought to be considered when applying the test of reasonableness. The question is whether the standard of reasonableness should be based upon a general practice or circumstance in which the medical practitioner acted under? What happens to doctors deprived of utensils in a rural hospital, who acted in the circumstance to save life and cause harm that was also preventable but for the lack of apparatuses? In *Cape Metropolitan Council v Graham*¹³³ it was stated that the circumstance of each case should indicate precautionary measures that were reasonably taken.¹³⁴ Value judgments will be used to determine whether the precautions were reasonable in the circumstance or not. Additionally, common practices that involve dangerous measures in public hospitals indicate the unreasonableness of the practice.

¹³¹ *Van Wyk v Lewis* 1924 AD 438. This was an action for damages for negligence in failing to remove the swab after an operation.

¹³² A Donabedian 'Evaluating the Quality of Medical Care' (1966) 44:3 *The Milbank Memorial Fund Quarterly*.

¹³³ *Metropolitan Council v Graham* 2001 (1) SA 1197 (SCA).

¹³⁴ *Ibid*.

Medical negligence can be caused in emergency circumstances. In terms of the ‘doctrine of sudden emergency’¹³⁵ a doctor is expected to act quickly in the face of imminent danger to exercise the same required duty of care vis-à-vis the doctor who is not acting under the same circumstances. In litigation the challenge would be to prove that the situation was one of imminent peril, not caused by the doctor’s own negligence¹³⁶ and that the doctor acted reasonably in the circumstances.¹³⁷ Furthermore, medical negligence is complicated by the difficulties in distinguishing whether the medical practitioner’s conduct was due to an error of judgment in the emergency situation. The complication is however that an error of judgment may also occur in ordinary circumstances.¹³⁸

The legal concept of duty of care

In most cases, the commission or omission of medical negligence is carried out by employees of public hospitals. The South African concept of duty of care in establishing negligence is strongly rooted in English law.¹³⁹ The courts have developed principles which require the establishment of whether the medical practitioners in public hospitals owed the patient the duty of care and whether this duty was indeed breached. If the answer is in the affirmative, medical negligence would have been established. Some scholars argue that direct or corporate hospital liability demonstrates a concept of duty.¹⁴⁰ On the other hand, Janulis and Hornstein attest that corporate liability induces corporate negligence.¹⁴¹ It is the basis of the dissertation that hospitals as essential institutions, owe a direct duty of care to their patients. Therefore they are impacted with the obligation to refrain from any omission or commission which could cause foreseeable damage or create an unreasonable risk of danger.

¹³⁵ Loubser, Midgley et al op cit note 119 at 127.

¹³⁶ *Msutu v Protea Assurance Co Ltd* 1991 (1) SA 583 (C), para 588 (H-J) although the circumstantial issues are different the principle of negligence under emergency stated is significant to this discussion.

¹³⁷ *Colman v Dunbar* 1933 AD 141, para 162 evidence must be of character that justify justice.

¹³⁸ Loubser, Midgley et al op cit note at 127; *Van Wyk v Lewis* 1924 AD at 438 at 444. However, experts such as surgeon are also required to act in accordance with the standard of expertise.

¹³⁹ *Cooke v Midland Great Western Railway of Ireland* [1909] AC 229.

¹⁴⁰ M Cronje-Retief *THE LEGAL LIABILITY OF HOSPITALS* (2000) at 354.

¹⁴¹ *Ibid.*

In addition, South African legislations provides for recognition of the moral duty of care. The Health Professions Act¹⁴² defines a medical practitioner as any person including a student registered with the council and under section 19 of this Act,¹⁴³ the Health Professions Council of South Africa, is empowered to regulate the conduct of medical profession. Therefore, South Africa has laws that govern how medical practitioners should treat patients. It is therefore easy to challenge medical negligence, because of the bench marks stipulated to ensure that patients' rights are always appreciated while exercising the duty of care. In addition the hospital's direct duties are also derived from common law duty of care.¹⁴⁴ This means that the duty of care ought to resemble such an inevitable health care obligation.

It is submitted that the disparity in "standard of care" between rural and urban public hospitals muddles the ability for one to challenge the level of skill the doctor should display, as they are subjected to one law in which the duty of care is derived from. This is inapplicable to different circumstances under which they operate. Furthermore, public hospitals as organs of State should be well resourced financially and with competent human resources to prevent breach of hospitals' fiduciary and moral duty of care.

In *Thompson v Nason Hospital*¹⁴⁵ the court laid the duties of hospitals as:

- i) A duty to use reasonable care in maintenance of safe and sufficient facilities and equipment.
- ii) A duty to select and retain only competent physicians
- iii) A duty to oversee all persons who practice medicine within its walls, as to patient care
- iv) A duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.

Although the plethora of criticism resonates around the breach of these duties by public hospitals in South Africa, the analysis of cases in the breach of duty

¹⁴² Health Professions Act 56 OF 1974.

¹⁴³ Ibid.

¹⁴⁴ Cronje-Retief op cit note.

¹⁴⁵ *Thompson v Nason Hospital* 527 Pa 330, 591 A 2d 703 (Pa 1991).

of care in various circumstances shows that it is a highly complex and difficult process to ascertain the intricate nature of negligence. This is further exacerbated by the question who has the evidence?¹⁴⁶

Burden of Proof

Burden of proof is the duty placed upon a party to prove or disprove contested facts.¹⁴⁷ In civil cases, the balance of proof is based upon balance of probabilities.¹⁴⁸ Balance of probability evidence implies that the other party to the issue in contest has more convincing evidence than the other party. In *St Augustine's Hospital (Pty) Ltd v Le Breton*¹⁴⁹ the court stated that the one who avers, has the burden of proof. The victim of medical negligence by hospital has to provide convincing evidence against the hospital for liability to ensue. However, illiterate and indigent victims find it difficult to discharge the onus that the public hospital doctors acted negligently. The failure by the victim to prove and abridge evidence on negligence will deprive him or her of the ability to claim for compensation.

Principle of *res ipsa loquitur*

Res Ipsa Loquitur means that the matter speaks for itself.¹⁵⁰ Patrick van den Heever, and Pieter Carstens, defines this maxim to mean that facts speak for themselves.¹⁵¹ Slabbert suggests that in medical negligence, *res ipsa loquitur* rule cannot be used by a patient.¹⁵² In *Stacy v Kent*¹⁵³ the court stated that the doctrine of *res ipsa loquitur* will only find application if these requirements are met:

- i) First, the occurrence must be of such nature that it does not ordinarily happen unless someone is negligent.

¹⁴⁶ Interview with Groote Schuur Hospitals Department of Medico-Legal, Observatory, Cape Town, Western Cape Health Department, Western Cape.

¹⁴⁷ B Garner *Black's law dictionary* (2009).

¹⁴⁸ W Twining and A Stein *Evidence and Proof* (1992).

¹⁴⁹ *St Augustine's Hospital (Pty) Ltd v Le Breton*. 1975 (2) SA 530.

¹⁵⁰ Cronje- Retief op cit note 141 at 413.

¹⁵¹ P van den Heever, and P Carstens *Res ipsa loquitur and medical negligence: a comparative survey* (2011).

¹⁵² M Slabbert 'THE REQUIREMENT OF BEING A "FIT AND PROPER: PERSON FOR THE LEGAL PROFESSION' (2011) 14:4 *African Journal of Psychiatry*.

¹⁵³ *Stacy v Kent* 1995 (3) SA 344 (E).

- ii) Secondly, the instrumentality must be within the exclusive control of the defendant.

It is the submission of this dissertation, that in order to determine whether to pursue litigation or not, both parties, victim and hospital ought to satisfy the condition of *res ipsa loquitur*. However, in litigation the challenge in proving medical negligence is difficult and compound for the victim without access to information that supports his or her allegation.¹⁵⁴ The *Lewis case*¹⁵⁵ emphasized that *res ipsa loquitur* does not find application with regard to medical negligence cases in South Africa. Nevertheless, in *Truter v Deyssel*¹⁵⁶ the SCA overturned the decision and held that the trial court erred in concluding that negligence cannot be drawn from a particular set of facts. Some scholars argue that the decision was correct in confirming the applicability of *res ipsa loquitur* in medical negligence cases.¹⁵⁷

It is submitted that *res ipsa loquitur* rule should be applied in circumstances where prima facie facts speak evidently of negligence on part of the hospitals. The principle should also be used as a technique of reasoning whether the parties should invoke medical litigation or (ADR) mechanisms. This will provide simplicity in trial avoidance.

Exemption Clause

Exemption clause is defined as contractual terms under which the hospital which drafted the agreement is protected from being sued by the patient for negligence.¹⁵⁸ Therefore, the patient's right to sue in terms of the agreement is limited by signing the standard contract with a clause excluding liability. The complexity is that the standard contracts are fixed and unilateral; therefore the patient

¹⁵⁴ Loubser, Midgley et al op cit note at 133.

¹⁵⁵ *Van Wyk v Lewis* 1924 AD.

¹⁵⁶ *Truter v Deyssel* 2006 (4) SA 168 (SCA).

¹⁵⁷ P. Carstens and D Pearmain *Foundational Principles of South African Medical Law* (2007).

¹⁵⁸ PN Stoop 'Current Status of the Enforceability of Contractual Exemption Clauses for the Exclusion of Liability in the South African Law of Contract' (2008) 20 *South African Mercantile Law Journal* 496; J O'Connell 'Elective No-Fault Liability by Contract: With or without an Enabling Statute' (1975) *University of Illinois Law Reform*.

is vulnerable to exploitation because of the weaker bargaining position.¹⁵⁹ In *Afrox case*¹⁶⁰ and *Napier v Barkhuizen*¹⁶¹ the SCA found that there was no evidence to infer unequal bargaining position. This complicates the legal position of the patient. Additionally by their nature, exemption clauses are problematic as parties struggle whether to bring their action in delict or contract.¹⁶²

Public hospitals have standard-form contracts with exemption clause signed by the patient upon admission characterized by its “take it or leave it” nature.¹⁶³ For instance, Groote Schuur Hospital provides ‘consent to medical procedure form’ signed by patients. The patient is required to sign that nature, risks and possible consequences of the medical procedure has been explained to him or her.¹⁶⁴ The question is whether such an exemption clause should be allowed to stand, vis-à-vis existence of gross negligence? The use of exemption clause has caused nuisance for the courts as some terms are unreasonable to the patients. Hence, imposing liability against the hospital for gross negligence based on exemption clauses is problematic for the victim.

As discussed earlier, it is a complicated to institute a claim for compensation based on fault.¹⁶⁵ The fact that exemption clauses are misapplied is indicative of their undesirable usage in public hospitals. In *Afrox Healthcare Bpk v Strydom*¹⁶⁶ the appellant relied on the exemption clause to escape liability. The respondent alleged that it was a tacit term of their agreement to be treated with professionalism and reasonable care. The SCA held that the exemption clause was not against public policy and that it has been contracted voluntarily. However, the court stated that what was significant was whether the exemption clause in the admission document was

¹⁵⁹ P Carstens and A Kok ‘An Assessment of the use of Disclaimers by South African Hospitals in view of Constitutional demands: Foreign Law and Medico-legal Considerations’ (2003) 18 *South African Public Law* 430 at 454.

¹⁶⁰ Carstens and Kok op cit note.

¹⁶¹ *Napier v Barkhuizen* 2006 (4) SA 1 (SCA); 2006 (9) BCLR 1011 (SCA).

¹⁶² Stoop op cit note 159 at 496.

¹⁶³ D Hutchison, CJ Pretorius, et al *The Law of Contract in South Africa* (2012).

¹⁶⁴ Consent to Medical Procedure Form, provided by Groote Schuur Hospital, Observatory, Cape Town, Western Cape Health Department, Western Cape.

¹⁶⁵ O’Connell op cit note 159.

¹⁶⁶ *Afrox Healthcare Bpk v Strydom* 2002 (6) SA 21 (SCA).

objectively not unexpected.¹⁶⁷ The fact that in the *Afrox case*¹⁶⁸ the court rejected the patient's argument about the exemption clause means that it will be a challenge to even prove with evidence that the patient was in a weaker bargaining position than the hospital.¹⁶⁹ The approach of the courts with regard to the position of inequality will make it difficult for patients to challenge gross negligence by the public hospitals. However, in terms of section 48 of the Consumer Protection Act,¹⁷⁰ unfair, unreasonable or unjust contract terms are prohibited and certain terms and conditions have to be drawn to consumers' attention and cannot be buried in the small print.¹⁷¹ Henceforth, the *Afrox*¹⁷² judgement would have to be submissive to this Act. Apart from the toil with litigation, the victim still has to prove that the admission clerk did not draw his or her attention to the exemption clause and that such clause is in conflict with principles of good faith.

As a result, it will be difficult for victims to challenge exemption clauses in the face of the SCA *Afrox case*¹⁷³ in which common law allows hospitals to exclude liability for medical malpractice resulting in death or physical or psychological injury except in the case of gross negligence, which may require expert witnesses, and viable evidence to prove gross negligence. The sophistication of medical negligence is augmented by the inability of judiciary to consider illiterate rural population without the ability to read and understand the unexpected or surprising clause contained in public hospitals' admission contracts. This exposes why litigation is a difficult avenue to prove medical negligence.

¹⁶⁷ *Afrox Supra* (n166) para 23-36.

¹⁶⁸ *Afrox Supra* (n166).

¹⁶⁹ A Joubert 'The Law of South Africa' (1999) 17 *First Reissue* para 193; T Naude and G Lubbe 'Exemption Clauses A Rethink Occasioned by *Afrox Healthcare BPK v Strydom*' (2005) 5:1 *South African Law Journal*.

¹⁷⁰ Consumer Protection Act No. 68 of 2008.

¹⁷¹ Consumer Protection Act No. 68 of 2008.

¹⁷² *Afrox Supra* (n166).

¹⁷³ *Afrox Supra* (n166).

Vicarious Liability

It should be noted that various theories of hospital liability have been constructed and engaged by the courts. Strict hospital liability has been introduced in many legal systems.¹⁷⁴ Vicarious liability is often used to institute legal liability against public hospitals for medical negligence disputes. According to Wille, vicarious liability entails that the employer can be held liable for delictual acts or omission committed by the employee, during the course of employment.¹⁷⁵ The doctrine of vicarious liability originated from English law, where hospitals were held to be vicariously liable for the negligence of their medical patients.¹⁷⁶ In terms of section 1 of State Liability Act,¹⁷⁷ any person can claim against the state for any wrong committed by the servant of the State acting in his capacity and within the scope of his authority. It is submitted that the common law principle of vicarious liability has become a well-established and inseparable part of South African law.

The courts are legally enthusiastic to invoke the doctrine of vicarious liability where facts of the case reveal an employer-employee relationship. Some early writers argue further that “scope of employment is defined as acts incidental or natural to the servant”.¹⁷⁸ Some scholars further suggest that “each case of vicarious liability must be determined by facts relevant to it”.¹⁷⁹ It is submitted that the doctrine of vicarious liability is a form of strict liability or could be regarded as a form of faultless delictual liability.¹⁸⁰ The rational position is that public hospital, as the employer, should be held strictly liable for medical negligence committed by its employees in the course of their employment. However, in *Minister of Law and Order v Ngobo*,¹⁸¹ court stated that strict liability does not simply rise due to intolerable high risks created by the defendant, but policy consideration also need to be taken into account. This may be problematic for the victim in that it may forsake the high risks created.

¹⁷⁴ Cronje-Retief op cit note at 63.

¹⁷⁵ G Wille, F Du Bois and G Bradfield Wille's *Principles of South African Law* (2007).

¹⁷⁶ *Feldman (Pty) Ltd v Mall* 1945 AD at 737.

¹⁷⁷ State Liability Act 20 of 1957.

¹⁷⁸ J Laski Harold 'The Basis of Vicarious Liability' (1916) 26:2 *Yale law Journal* at 115.

¹⁷⁹ Laski Harold op cit note 180 at 114.

¹⁸⁰ Van de Walt *THRHR* (1964) at 213

¹⁸¹ *Minister of Law and Order v Ngobo*, 1992 (4) SA 822 (A).

In *Gibbins v Williams, Muller, Wright and Mostert Inc*¹⁸² the court stated that in order to determine the applicability of vicarious liability for the employees, four *indicia* were emphasized: i) the employer's right to employ the employee, ii) the payment of wages, iii) the employer's right to control the method of work and iv) the employer's right to dismiss the employee. According to Cronje the requirements of vicarious liability are also acknowledged in South African law.¹⁸³ The burden will be upon the victim to show the existence of an employer- employee relationship at the time the wrong is committed.¹⁸⁴ This is done by proving that the hospital had the right and power to control the manner in which the work was being done by employee. Furthermore, under organizational test¹⁸⁵ which is regarded as a better test than control test,¹⁸⁶ the victim has enormous responsibility to prove that the medical practitioner was integral part of the public hospital. Although it is complex to prove gross medical negligence, in establishing strict liability for public hospitals, it is the proposition of the dissertation that the victim should use both tests to ascertain vicarious liability for the hospital.

Causes of medical negligence

There are myriad causes of medical negligence however; for the purpose of this dissertation it shall be necessary to explore the most common causes of negligence in South African public hospitals by nurses and doctors. In addition, the complexity of proving such "causes" will be considered.

Misdiagnosis

One of the causes of medical negligence in public hospitals is misdiagnosis or delayed diagnosis of the medical condition. The eventual consequence of misdiagnosis is that the patient will be a recipient of an incorrect treatment. According to Smink and others, the ratio of doctor to patients at a certain hospital

¹⁸² *Gibbins v Williams, Muller, Wright and Mostert Inc and Another* 1987 (2) SA 82 (T).

¹⁸³ Cronje-Retief op cite note.

¹⁸⁴ Crogan *Workplace Law* (2009); J Neethling *Law of Delict* (2010).

¹⁸⁵ Kahn- Freud *MLR* 1951 at 504- 509.

¹⁸⁶ Cronje-Retief op cite note.

contributes to diagnostic accuracy.¹⁸⁷ The scholars attest language barrier as a contributory factor to misdiagnosis in public hospitals.¹⁸⁸ Hayward propound that medical errors contributes to preventable deaths.¹⁸⁹ Therefore, communication barrier between the doctor and patient causes misdiagnosis in public hospitals. Misdiagnosis can also be caused by the doctor or technician that misread the pathology slide. For the patient it can be a challenge to prove that negligence was caused by the doctor (human error) and not faulty equipment.¹⁹⁰

Childbirth Injuries and death

In most public hospitals childbirth injuries and death are due to negligence by medical practitioners, doctors and nurses. Nordqvist attests that if the current lack of oversight, accountability, and abuse by medical staff in public hospitals continues South Africa's goal of reducing its high maternal death rate by 75% between 1998 and 2015 will not be realized.¹⁹¹ In public hospitals, the patients are pinched, slapped, and handled roughly during labor. It is also noted that nurses do not respond to calls for help by women in labor and after delivery, in which most of the maternity patients are left unattended.¹⁹² In addition, most maternal death in public hospitals occurs between the third trimester and the first week after the end of pregnancy.¹⁹³ The treatment and professional intrapartum care¹⁹⁴ causes childbirth injuries and even death in public hospitals. However, to prove birth defect or injury is a difficult matter and the process to determine, which can be can be long and draining. In that it may require medical lawyers working with medical experts to evaluate prenatal

¹⁸⁷ DS Smink, A Finkelstein, K Kleinman and SJ Fishman 'The Effect of Hospital Volume of Pediatric Appendectomies on the Misdiagnosis of Appendicitis in Children: in PEDIATRICS' (2004) *Official Journal of the American Academy of Pediatrics*.

¹⁸⁸ Ibid.

¹⁸⁹ RA Hayward 'Estimating Hospital Deaths Due to Medical Errors: Preventability Is in the Eye of the Reviewer' (2001) *Journal of the American Medical Association (JAMA)*.

¹⁹⁰ K Michon Medical Malpractice: Misdiagnosis and Delayed Diagnosis: How the wrong diagnosis or late diagnosis from your doctor can lead to a medical malpractice lawsuit, available at <http://www.nolo.com/legal-encyclopedia/medical-malpractice-misdiagnosis-delayed-diagnosis-32288.html>, (accessed on 28 August 2013).

¹⁹¹ C Nordqvist *The Shocking Truth about Giving Birth In South Africa* (2011).

¹⁹² Nordqvist op cit note.

¹⁹³ XF Li, JA Fortney, M Kotelchuck and LH Glover 'The postpartum period: the key to maternal mortality' (1996) *Int J Gynaecol Obstet*, (1996) at 54.

¹⁹⁴ C Ronsmans and W Graham 'Maternal mortality: who, when, where, and why' (2006) 368 *The Lancet Maternal Survival Series*.

records, hospitals records and electronic fetal heart tracing.¹⁹⁵ This makes litigation an undesirable procedure compared to ADR.

Anesthesia Errors

Anesthesia error is defined as an error by the anesthesiologist, doctor or other medical staff during surgery. This can be caused by too much, too little anesthesia or any other mistake due to lack of proper care by the medical practitioners.¹⁹⁶

According to Rout and Farina, the total number of deaths due to anesthesia between 2005 and 2007 in all South African provinces was at 74 which increased between 2008 and 2010 to 92.¹⁹⁷ Most deaths are associated with pregnancy complications.

It is reported that spinal anesthesia accounted for 79% of the death and general anesthesia accounted for 16%.¹⁹⁸ This is being caused by lack of simple skills in anesthesia, which encompasses assessment and resuscitation, as the main cause of such.¹⁹⁹ In public hospitals the number of reported deaths will continue to increase and negligence can also results in disability such as paralysis brain injury. However, since the victim is asleep at the time of the error, it may be difficult to prove negligence for compensation due to anesthesia.²⁰⁰ To accumulate and evaluate all the evidence on such cases requires skilled medical lawyers and medical experts.²⁰¹

Medication or Prescription errors

Medication error is an event that occurs as a result of actions taken by a medical practitioner in prescribing, dispensing or administration of a drug,

¹⁹⁵ J Greenwood and S Ulan The Birth Injury Case: Proving Malpractice (Part I, available at <http://www.greenwoodlawoffice.com/article-proving-malpractice-part-1.php>, (accessed on 28 August 2013).

¹⁹⁶ G Lamacraft, PJ Kenny, BJS Diedericks, G Joubert 'Obstetric anaesthesia: the source of the crisis' (2008) *South African Medical Journal*.

¹⁹⁷ CC Rout and Z Farina 'Anaesthesia-related maternal deaths in South Africa Chapter Seven of the 5th Saving Mothers' Report 2008-2010(2012) *South Africa Journal Anaesthesia and Analgesia* at 282.

¹⁹⁸ Rout and Farina op cit note at 282.

¹⁹⁹ Rout and Farina op cit note at 282.

²⁰⁰ M Kennerly Anesthesia Complications in Routine Surgery, 19 December 2011, available on <http://www.litigationandtrial.com/2011/12/articles/attorney/medical-malpractice-1/anesthesia-malpractice>, (accessed on 28 August 2013).

²⁰¹ Kennerly op cit note 201.

irrespective of whether such errors lead to adverse consequences or not. Such are the single most preventable cause of patient harm.²⁰² In public hospitals the question resonates as to whether the medical professionals are competent to measure up to the challenges they face daily in their work.

Interestingly, Williams supports such a position by stating that the cause of medication errors is largely due to relatively inexperienced medical staff responsible for the majority of prescribing in hospital.²⁰³ It is argued that the common causes of medication error may be due to the difficulty in reading handwritten orders, confusion about different drugs with similar names, and lack of information about a patient's drug allergies or sensitivities.²⁰⁴ It can be a challenge in proving that the prescriber erred in prescribing the drug.

Incompetence and shortage of staff

The primary purpose of a district hospital is to deliver suitable out- and in-patient care in which medical, nursing and other professionals provide appropriate care to the patient's condition.²⁰⁵ However, due to shortage of staff most of the public hospitals are failing to meet the demand within the catchment area they serve. This is contributed by emigration to developed countries or internally to private sector, with superior remunerations.

Monwabisi Bevan Goqwana²⁰⁶ argued that discrepancy between the total number of medical institutions in South Africa and the demand of medical practitioners is too wide. This means that the bulky of the medical professions, especially doctors and nurses in this case, are rushed in the system to meet the growing demand. This compromise the quality of the medical practitioners as public hospitals tends to be end recipients of the half-baked workforces.²⁰⁷ Additionally, the shortage of staff has resulted in compelling the few available to work over-time and

²⁰² DJP Williams 'Medication errors' (2007) *Journal - Royal College of Physicians of Edinburgh*.

²⁰³ Williams op cit note 202.

²⁰⁴ National Coordinating Council for Medication Error Reporting and Prevention (NCCMERP) (2000).

²⁰⁵ K Cullinan *Health services in South Africa: A basic introduction; Health-e News Service January* (2006)

²⁰⁶ Interview with Monwabisi Bevan Goqwana, Chairperson for HEALTH PORTFOLIO COMMITTEE; South African Parliament (2013).

²⁰⁷ Op cit note.

are left exhausted. This results in poor quality of care and avoidable morbidity and mortality.²⁰⁸ It is submitted that the victim would have to prove incompetence as the cause of the injury by comparing, what the public hospital treating doctor did or omitted to do, and how other competent doctors within the similar speciality would have handled the case. If the hospital is situated in rural setting, the determination of incompetence may be difficult and compromised by unavailability of right equipment.

Shortage of facilities/ substandard medical care

The shortage of facilities in public hospitals results in medical carelessness and mediocre service being delivered in public hospitals. The fact that public hospitals are provincially administered means the monitoring of their budgets is problematic. Many provinces are still administratively weak and lack the capacity to do what they are supposed to do.²⁰⁹ In 2004, six out of the nine provinces in South Africa under-spent their health budgets due to a lack of capacity.²¹⁰ The shortage of facilities will remain a barrier to mitigating the variance of medical negligence in public hospitals.

The difficult question is which standard of attributing fault should be used to a medical practitioner at a rural public hospital with a large catchment area compared to one at urban public hospital, with a small catchment area. They are both exposed to different facilities, and medical care? Given this context it may be difficult for the victim to prove gross medical negligence through adjudication, it is submitted that ADR mechanism provides a viable alternative to resolve similar disputes.

Analysis of certain Medical Negligence Cases

In the case of *Galaletsang Ursula M Kgosiemang v Member of the Executive Council: Department of Health, North West*²¹¹ the plaintiff suffering from headache and dizziness was given booster vaccinations and injected with unknown substance. It was alleged that plaintiff was misdiagnosed by the defendant

²⁰⁸ K von Holdt and M Murphy Management of public hospitals in South Africa: Public hospitals in South Africa: Stressed institutions, disempowered management (2006).

²⁰⁹ Cullinan op cit note 206.

²¹⁰ Ibid.

²¹¹ *Galaletsang Ursula M Kgosiemang v Member of the Executive Council: Department of Health, North West* (308/2011) [2013] ZANWHC 14 (14 February 2013).

and due to misdiagnosis the plaintiff suffered from an ailment that required Phenobarb be prescribed. Error in medication was negligently given. The court referred to *Mitchell v Dixon*²¹² in which it was stated that reasonableness will be considered based on general level of skill and diligence possessed and exercised by members of the profession to which the practitioner belongs. The defendant was liable for damages due to the failure by the medical staff at the Thusong Hospital to refer the plaintiff to an ophthalmologist.

In *Sonny and Another v Premier, KwaZulu-Natal, and Another*,²¹³ the plaintiff instituted an action in the High Court claiming for negligent-related damages which caused the child to be with Down's syndrome and the wife sterilized without her consent. Medical professionals breached their duty to monitor the wife's pregnancy due to her age and perform various tests to determine the normalcy of the foetus. The court held that a reasonable person in the position of a doctor would have foreseen the reasonable possibility of the patient's falling through the cracks and not returning to the hospital and necessary for the doctor to have given written instruction of having an urgent scan. The court held that the defendant was liable for the omission that resulted in the child born with Down syndrome, but absolved from the sterilization act. It is the position of this dissertation that where 'facts speak for themselves' that negligence was committed ADR mechanisms should be adopted and utilised to the benefit of both parties.

In *Louwrens v Oldwage*²¹⁴ the plaintiff patient was diagnosed by a vascular surgeon based on the symptoms presented by the patient. Under High Court, the plaintiff sued the defendant for misdiagnosis. In that the plaintiff had severe ischaemia, which required urgent surgical intervention in the form of bypass operation. On further consultation with neurosurgeon, it was discovered that the patient had disc degeneration at the L4/5 vertebrae, which had resulted in a prolapsed A disc. In the High Court, it was held medical practitioner had made an incorrect diagnosis. However, on Appeal, such was reversed; expert evidence showed that the plaintiff had critical ischaemia, which he defined as a progression from intermittent

²¹² *Mitchell v Dixon* 1914 AD at 525.

²¹³ *Sonny and Another v Premier, KwaZulu-Natal, and Another* 2010 (1) SA 427 (KZP) 2010 (1) SA.

²¹⁴ *Louwrens v Oldwage* 2006 (2) SA 161 (SCA).

claudication which is described as lameness, a weakness, a pain, and a cramp which usually starts in the calf muscle. The SCA considered dilemma doctors face when they fail to disclose certain risks to the patient, on the other hand if he discloses them might frighten the patient into not having the operation, when it is in the patient's interest to have it. It is the position of this dissertation that in certain circumstances, if a doctor fails to warn the patient, in principle his conduct should be considered against the standard of a reasonable person.

In *Truter v Deysel*,²¹⁵ the respondent instituted action in the High Court against the appellants for damages arising from a personal injury sustained by him as a result of a series of medical and surgical procedures performed by the appellants. The case was concerned with the prescription period for claiming damages, in terms of s 11(d) of the Prescription Act.²¹⁶ Six operations performed on Deysel gave rise to claim. It was argued that Truter's surgery irreparably damages the endothelial cells lining the cornea of Deysel's eye. It was argued that Truter could have reasonably foreseen the need of a corneal graft and, if not uncomplicated, eventual loss of the eye if an infection was to set in? The Appeal for special plea of prescription was upheld. It is submitted that in order to ascertain negligence litigation procedure can be affected by prescription, if the aggrieved party fails to institute an action within the prescribed time. Such may impede chances of the patient to succeed in compensation under litigation and the patient may not necessarily win the negligence case, unless the proper procedure is adopted and followed.

In 2012 the Pretoria High Court ordered Gauteng Health MEC Hope Papo to pay damages to Thembisa Kometsi whose legs were amputated after she was admitted for treatment of burnt hands at the Far East Rand Hospital.²¹⁷ In addition, Nicholaas van Niekerk was brain damaged as a result of medical negligence at the Charlotte Maxeke Johannesburg Academic Hospital.²¹⁸ Court precedents are indicative of complexities encountered and the amount of evidence required for the public hospitals to be held liable for medical negligence caused by medical practitioners.

²¹⁵ *Truter v Deysel* [2006] SCA 17 (RSA).

²¹⁶ Prescription Act 68 of 1969.

²¹⁷ Ibid.

²¹⁸ Ibid.

In conclusion, establishing medical negligence is a mammoth task that requires time, human and financial resources. The traditional litigation system demonstrate the complexities that dislodges itself as useful procedure vis-à-vis ADR postures itself as a viable alternative that can be used to resolve medical negligence disputes.

CHAPTER 3: ALTERNATIVE DISPUTE RESOLUTION MECHANISMS AND MANDATORY MEDIATION RULES

Introduction

Description of Alternative Dispute Resolution

Alternative Dispute Resolution (ADR) encompasses various techniques which parties to the dispute may use to settle their disputes outside the framework of the traditional litigation system.²¹⁹ Most writers justify ADR mechanisms principally on the basis that they save time and expenses.²²⁰ An additional benefit of ADR is that it can be molded to suit the specific needs of parties to enhance speedy settlement of conflicts.

The judicial system's inability to handle the current litigation load, including the cases of medical negligence, indicates the need to prepare for such litigation storm. ADR is a practical option. ADR has its modern roots in the United States of America, although it has ancient origins.²²¹ In the USA the expanded use of ADR was noted in the Pound Conference of 1976 (also known by the conference theme - 'Causes of Popular Dissatisfaction with the Administration of Justice'), which promoted legal reform by encouraging ADR processes.²²²

ADR manifests itself in various forms. Hence, ADR was conceived after synchronized dissatisfaction with the litigation system in failing to realize justice within reasonable time and the necessity of cutting down on litigation costs associated with the adversarial system. Firstly, it acquires a conflict avoidance

²¹⁹ P Talibah *Alternative Dispute Resolution: A Study of the History and Function of ADR Techniques As Mechanisms For International Peacekeeping* (2000).

²²⁰ WE Trachte-Huber and SK Huber *Alternative Dispute Resolution, Strategies for Law and Business* (1996).

²²¹ Africa has long practiced mediation in its traditions: see RBG Choudree 'Traditions of Conflict Resolution in South Africa' (1999) 1 *African Journal on Conflict Resolution*, available at www.accord.org.za, (accessed on 03 September 2013); Historians trace mediation practices back to Babylonian and Phoenician commerce. This shows mediation as an ADR mechanism has long been established as a norm to resolve conflict.

²²² Trachte-Huber and Huber op cit note 222.

position through the strategy of negotiation, in which parties attempt to focus on shared interests and mutual benefits in resolving the conflict. Negotiation is defined as a discourse between two or more parties with the intention to resolve the differences, by compromising to reach an understanding and conclude a mutual settlement.²²³

Secondly, mediation is also considered where the intercession of a neutral third party is utilized as a way of assisting the parties to reach a mutually acceptable settlement. A mediator can be used in resolving medical negligence disputes, even though these are generally rights-based as opposed to interest-based disputes. Arbitration, too, is significant because, the decision of the arbitrator is binding upon parties, which may be an important requirement of finality. This chapter shall to a lesser extent look at negotiation, and arbitration. However, the paper shall to a large extent dwell on mediation and how mediation can be used in conjunction with litigation in medical negligence disputes, in South Africa.

The ethical issues arising in ADR

It is a legal requirement for attorneys and advocates to be regarded as persons 'fit and proper' in their undertakings. Slabbert argues that in order to be "fit and proper" a person must show integrity, reliability and honesty, as these are the characteristics which could affect the relationship between a lawyer and a client.²²⁴ In terms of section 7(1) (d) of the Attorneys' Act²²⁵ and Section 22(1) (d) of the Advocates' Act,²²⁶ legal practitioners can be removed if their conduct is unethical, thus not fit and proper. In terms of Health Professions Act,²²⁷ medical practitioners are required to subscribe to ethical rules in their conduct.

²²³ R Fisher and B Ury *Getting To Yes: Negotiating Agreement without Giving In* (1981); R Fisher and D Ertel *Getting Ready to Negotiate* (1981).

²²⁴ Slabbert op cit note 153 at 216-214.

²²⁵ Attorneys Act 53 of 1979.

²²⁶ Admissions of Advocates Act 74 of 1964.

²²⁷ Health Professions Act of 1974.

According to Rycroft, the regulation of ethics of negotiation is a highly contested and relatively uncertain area.²²⁸ However, author argues that this should not prevent an investigation as to the essence of ethics in negotiation.²²⁹ Some scholars argue that the ability to mislead the other party about one's true position is the essence of negotiation.²³⁰ However, Rycroft writes that ethical negotiation should be based upon mutual trust principle, in which negotiation develops mutual trust and fair treatment in which accurate information is not be compromised.²³¹ This allows parties to refrain from regrettable conduct that will cause incremental risks and costs. Although Rycroft agrees with Fisher and Ury²³² on principled negotiation as the way forward, he argues further that in South Africa good faith is not a prerequisite for reaching a settlement. This is contributed by definitional problems as to what constitute good faith bargaining.²³³

The medical practitioners and legal practitioners, whilst fulfilling their negotiation and mediation roles have the duty to obey the law that regulates the negotiation and mediation process. In South African law, the common law position is that misrepresentation, fraud and duress are unlawful.²³⁴ However, in South Africa fraud is not regulated.²³⁵ Hence normative concerns under ADR require ethics to be adhered to. This is supported by Shell,²³⁶ who argues that the idealist school of ethics requires one to 'do the right thing even if it hurts' by being honest in negotiation. This also means that the victim of medical negligence has the duty to be honest and disclose all material information about the injury caused by public hospitals and not exaggerate the circumstances. Therefore, deception should not be justified under ADR mechanisms.

²²⁸ A Rycroft 'Settlement and the law' (2013) 130 *South African Law Journal* at 190.

²²⁹ Rycroft op cit note at 190.

²³⁰ JJ White 'Machiavellie and the Bar: Ethical limitations on lying in negotiation' (1980) 4 *American Bar Foundation Research Journal* at 926.

²³¹ Rycroft op cit note 193.

²³² Fisher and Ury op cit note 225.

²³³ Rycroft op cit note 196.

²³⁴ Rycroft op cit note at 187-209.

²³⁵ Ibid.

²³⁶ RG Shell *Bargaining for Advantage: negotiation strategies for reasonable people* (2006).

Role of Lawyers in ADR mechanisms

In negotiation, the discrepancy in power play that exists between State and victim, psychologically affect the legitimacy of the process,²³⁷ and works against the victim of medical negligence.²³⁸ In negotiation, due to technicalities and complexities that characterise medical negligence, medical lawyers or specialist negotiators should be involved in the process. Unassisted negotiation is not desirable with regard to medical negligence, because the victim may not be well vested of the issues at stake. The role of the legal representative in medical negligence is to negotiate a settlement in the best interest of the victim but within the confinement of what is ethical and legal.

In South Africa Uniform Rules²³⁹ that administer Advocates is limited in that it does not seem govern negotiations directly.²⁴⁰ Rycroft argues further that there is little guidance on ethics as to how lawyers ought to negotiate.²⁴¹ However, in terms of Rule 3.1²⁴² the counsel ought to declare and defend the rights of the client in the negotiation process.²⁴³ Rycroft argues that there are various ways of acting in the client's interest without misleading the opponent.²⁴⁴ Rule 3.2 provides that a lawyer should negotiate knowing fully that the client's bottom line is confidential and it would be improper to disclose it to the opponent.²⁴⁵ Hence, in terms of South African law,²⁴⁶ the lawyer as an agent must adhere to the client's instructions, in compromising and reaching a settlement with implied authority, provided that he or she acts in good faith in the best interest of the client.²⁴⁷ It is argued that Uniform

²³⁷ L Boule and A Rycroft *MEDIATION Principles Process Practice* (1997) at 53-54.

²³⁸ Boule and Rycroft op cit note 239 at 53-54.

²³⁹ GENERAL COUNCIL OF THE BAR OF SOUTH AFRICA: UNIFORM RULES OF PROFESSIONAL CONDUCT, available at www.sabar.co.za/GCB-UniformRules-of-Ethics, accessed on 25 September 2013.

²⁴⁰ Rycroft op cit note at 205.

²⁴¹ Rycroft op cit note at 205.

²⁴² Uniform Rules for South African Advocates

²⁴³ Professional Conduct Rule 3.1.

²⁴⁴ Rycroft op cite note.

²⁴⁵ Professional Conduct Rule 3.2.

²⁴⁶ *Hlobo v Multilateral Motor Vehicle Accident Fund* 2001 (2) SA 59 (SCA).

²⁴⁷ Rycroft op cite note at 206.

Rule 35 unless the rules of the court require disclosure, a counsel is not obliged to reveal any information that weaken his client's case.²⁴⁸

The International Code of Ethics has been incorporated with the rules, the Code for Ethics for Legal Practitioners²⁴⁹ and the IBA's General Principles for the Legal Profession.²⁵⁰ Rycroft argues that all these abovementioned codes require exercise of integrity, honesty and candidness in promoting the interests of the client.²⁵¹ However, the lawyer must not assist the client in violating any law or legal obligations owed to others. The lawyer has the right to withdraw, if the client's instruction for negotiation is contrary to the lawyer's ethical obligations.²⁵² It is submitted that with the introduction of mandatory mediation in South Africa, ethics of lawyers ought to be clarified in detail.²⁵³

Negotiation

Gulliver defines negotiation as a problem-solving process in which parties attempt to reach a joint decision with regard to issues in disagreement. This is facilitated by an exchange of information, by exploring the nature and extent of their differences and how their divergent expectations can be met satisfactorily.²⁵⁴ In this dissertation, negotiation refers to a process by which parties to medical negligence dispute resolve the matter by discussion with the intention to reach a settlement agreement on compensatory terms. The essence of this technique is that parties can resolve medical negligence dispute within a private setting. It is the position of this dissertation that the exchange of information between public hospitals and the victim's legal representative, verbally and through documentary evidence, strengthens the chances of parties to reach an agreement.

²⁴⁸ Ibid.

²⁴⁹ Rule 2 provides that the counsel should adhere to the standards of honesty, integrity and independence throughout the negotiation process.

²⁵⁰ IBA's General Principles for the Legal Profession 2006; the counsel has to treat the client's interest as paramount at all times and to observe law and ethical standards.

²⁵¹ Rycroft op cite note.

²⁵² C Menkel-Meadow and M Wheeler *What's Fair: Ethics for Negotiators* (2004); BC Haussmann 'The ABA Ethical Guidelines for settlement negotiations: Exceeding the limits of the adversarial ethics' (2003-2004) 89 *Cornel LR* at 1218.

²⁵³ Rycroft op cite note.

²⁵⁴ PH Gulliver *Disputes and Negotiations: A Cross –Cultural Perspective* (1979) at 79-80.

As stated earlier, ethical rules should be applicable when attorneys negotiate the settlement of disputes, honestly and in the best interest of their clients. Richard Shell argues that everyone has the duty to obey the law that regulates the negotiating process.²⁵⁵

Negotiation has the potential to be effective if used outside litigation settings²⁵⁶ in tackling medical negligence upsurge. The principle of litigation avoidance should be adopted by public hospitals when they react to a letter of demand. It is at this crucial moment, that there needs to be an opportunity for good faith ‘simple bilateral negotiation’,²⁵⁷ because the letter of demand will have contained an inflated demand, which is often an inflated figure that forces the hospitals to defend the action. According to Trachte-Huber and Huber in negotiation, it is necessary for the negotiating parties to determine the “Best Alternative To a Negotiated Agreement” (BATNA).²⁵⁸ If negotiation is unsuccessful, the victim or the State ought to have worked out in advance the alternative to a settlement. This is most often litigation. It is the position of this dissertation that for the negotiated settlement to be legally valid and enforceable, the agreement has to be aligned with the rules of ethics.

Negotiation allows parties to avoid the risks and uncertainties associated with litigation, as the agreement can be couched according to the parties’ specific preferences. In addition, parties would evade the costs associated with litigation and emotional stress associated with the adversarial system, which takes an average of three to six years to conclude a single case. In Chapter 2 it was noted that the State did not win all contested cases. Hence, in the context of budgetary constraints and unnecessary litigation costs, negotiation becomes a better alternative for public hospitals. In addition, the negotiation approach considers community interests and enhances the long term relationship of the victim and the doctor.

²⁵⁵ R Shell *Bargaining for Advantage: negotiating strategies for reasonable people* (2006) at 216.

²⁵⁶ J Macfarlane ‘Why do people settle’ (2001) 46 *McGill law Journal*.

²⁵⁷ J David *Alternative Dispute Resolution-What is it? In Alternative Dispute Resolution Proceedings* (1986).

²⁵⁸ Trachte-Huber and Huber op cite note.

Limitations of negotiation as a technique

The obstacles of using negotiation are that it is based on voluntariness: if the other party is not eager, negotiation cannot start. The parties need to consider mutual interest, thus to focus on interest not positions.²⁵⁹ Therefore, if the parties resort to hard negotiation without the use of soft negotiation skills such as compromise and accommodation negotiation may not be useful to tackle medical negligence claims. According to Boulle and Rycroft negotiation can only work if both parties are prepared to engage with creative capacity.²⁶⁰ If parties have to deal with a distributive issue, it is a challenge for parties to disclose substantial information or provide creative options for settlement.²⁶¹ Negotiation of compensation in medical negligence cases will likely encounter such inevitable difficulties. Therefore, in resolving medical negligence disputes both the victim and State ought to be cooperative and employ problem-solving skills rather than a competitive approach. This means problem-solving is not soft bargaining, but is a bona fide effort to focus on the problem and not the person, and to meet as many interests as possible through generating multiple options for settlement. However, negotiation does not exist in isolation but is an essential ingredient for the mediation technique.

Arbitration

Arbitration is another ADR mechanism used outside the court setting. Arbitration involves the use of a third party 'arbitrator' to resolve disputes in which her/his decision (award) will have a legally binding and enforceable consequence upon the parties.²⁶² Arbitration can be voluntary or compulsory, binding or non-binding.²⁶³ However, it is undesirable for arbitration to be regarded as a compulsory vis-à-vis medical negligence cases. It is the position of this dissertation that if the state adopts arbitration, time and costs of litigation will be saved by the state, because it is similarly time sensitive like any of ADR methods. However, it can be contested that arbitration equally takes a long time and parties have to pay for an

²⁵⁹ Ibid at 42.

²⁶⁰ Boulle and Rycroft op cit note at 53-54.

²⁶¹ Ibid.

²⁶² J Mugford *Alternative Dispute Resolution* (1986).

²⁶³ Mugford op cit note 262.

often expensive arbitrator, rather than getting a free judge. Hence it does not result in saving costs. Mugford writes that arbitration is a structured third party intervention compared to negotiation which is unstructured.²⁶⁴ This means that arbitration is characterized by formalities when associated with negotiation.

In South Africa, the Commission for Conciliation Mediation and Arbitration (CCMA) was designed to deal with labour disputes.²⁶⁵ Section 115 (2A) of Labour Relations Act (LRA)²⁶⁶ delegates power to CCMA to create rules for ADR such as arbitration, hence Rule 18 of Commission for Conciliation Mediation and Arbitration²⁶⁷ provides that a party may request the Commission to arbitrate. The existence of such forum shows that arbitration can potentially be of effective outside labour disputes. Compulsory arbitration can be achieved through an arbitration agreement, which is a written agreement between public hospitals and the patient, stipulating that in the event of medical negligence claim arising, both the patient and the public hospital will agree to arbitrate.²⁶⁸ Patients ought to be alerted to the consequences of agreeing to the use of arbitration prior to signing. Courts will ordinarily enforce such terms like any other agreement. Under arbitration, parties submit to the authority of the arbitrator, who has the discretion to apply law, and his binding decisions correspond to judgments.²⁶⁹ Arbitrations must conform to the requirements in the Arbitration Act.²⁷⁰

Benefits of medical negligence arbitration

Arbitration is regarded as a voluntary process by which parties agree to its use and binding nature, subject to limited rights of appeal.²⁷¹ Arbitration aims to reach a decision based on the merits of the case.²⁷² Parties to arbitration have

²⁶⁴ David op cit note 257.

²⁶⁵ CCMA was established in terms of Labour Relations Act of 1995 (LRA) as an independent body.

²⁶⁶ Labour Relations Act 66 of 1995.

²⁶⁷ Commission for Conciliation Mediation and Arbitration, available at <http://www.ccma.org.za>, (accessed 04 June 2013).

²⁶⁸ E Rolph, E Molle and JE Rolph 'Arbitration Agreements in Health Care: Myths and Reality' (1997) 60 *Law & Contemp.* at 153, 156-157.

²⁶⁹ The Chartered Institute of Arbitrators: *Guidelines for Conciliation and Mediation* (1990).

²⁷⁰ South African Arbitration Act 42 of 1965.

²⁷¹ TB Metzloff 'Unrealized Potential of Malpractice Arbitration' (1996) 31 *Wake Forest Law Review*.

²⁷² Metzloff op cit note 271.

substantial power to determine the details of the arbitration procedure.²⁷³ In addition, parties can determine the length of arbitration hearing, number of arbitrators, qualification of arbitrators, process of selecting arbitrators and the amount of discovery that should be allowed.²⁷⁴ Hence, a benefit of this mechanism is that it resolves medical negligence cases in a private and not public hearing. Other benefits of arbitration are that confidentiality is required of the arbitrator parties can agree on the appointment of an arbitrator with medical or specialist knowledge instead of a judge.²⁷⁵ Henceforth, it is more informal and less intimidatory environment for the patient, allowing more flexibility in arranging when and where the arbitration will take place. Therefore, arbitration remains feasible in tackling medical negligence cases compared to the traditional litigation system. To entrench arbitration in South Africa, arbitration agreements can be used in public hospitals prior to the treatment of patients. This will allow arbitration to be utilized rather than resorting to medical litigation.

Limitations of arbitration as a technique

However, in the context of the medical negligence dispute, the formality required by arbitration can be the same as in litigation. The costs one can incur by using arbitration can correspond to the litigation system. The procedural technicalities which require rules of evidence and procedure, though potentially more relaxed, are usually as formal as in litigation.²⁷⁶ However, in terms of section 14 (1) of Arbitration Act,²⁷⁷ if the arbitration agreement does not stipulate the rules for the conduct of the arbitration proceedings, the arbitrator will discover evidence as guided by the Act.²⁷⁸

One of the frequent allegations is that patients often involuntarily waive their right to litigation due lack of knowledge as to what they will be signing. Patients may prefer litigation compared to arbitration, due to the perception that the amount

²⁷³ Ibid.

²⁷⁴ Metzloff op cite note.

²⁷⁵ Metzloff op cit note.

²⁷⁶ TS Azadon and FA Tsegah 'Arbitration and the Settlement of Commercial Disputes: A Selective Survey of African Practice' (1975) 24:3 *International and Comparative Law Quarterly*.

²⁷⁷ South African Arbitration Act 42 of 1965.

²⁷⁸ Ibid.

of compensation awarded by courts is higher than in arbitration. Some scholars argue that the emotional aspects regarding medical negligence claims may compel patients to litigate.²⁷⁹

Mediation

Mediation involves the use of a neutral and impartial third party to assist the parties to settle contested issues.²⁸⁰ Mediation is less formal than arbitration, because the mediator has no authoritative decision making powers to assist the parties in the dispute to reach a mutually acceptable settlement.²⁸¹ The role of the mediator is to facilitate effective communication between the parties and to focus on the real issues of the dispute and to assist in generating options of settlement.²⁸² Mediation is different from the adjudication system in that in mediation decisions are made by parties and are not binding compared to court judgments. However a settlement agreement reached in mediation is as enforceable contract as any other. Mediation is informal and non-adversarial in nature.²⁸³ Some scholars demonstrate that mediation is appropriate where it is likely to result in a settlement acceptable by both parties.²⁸⁴ Hence, it is equally as appropriate in situations where one of the parties decides to compromise.

Mandatory mediation rules

The Rules Board for Courts of Law (Rules Board) is authorized by section 6 (1) of the Rules Board for Courts Law Act²⁸⁵ to review existing rules of the court. In addition, it is also mandated to enact rules for the Lower Courts, High Courts and Supreme Court of Appeal to enhance litigation practice. Following these powers enshrined for Rules Board mediation rules have been proposed for Magistrate Courts. The phraseology of Court-Annexed Mediation Rules means that mediation will be integral part of court. Following this mediation is now enforced by the force

²⁷⁹ AH Nevers 'Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?' (2000) 1 *Pepp. Disp. Resol. Law Journal* at 45, 47.

²⁸⁰ CW Moore *The Mediation Process: Practical Strategies For Resolving Disputes* (1986).

²⁸¹ K Kovach *Mediation, Principles and Practice* (1994).

²⁸² M Alberstein *Forms of Mediation and Law: Cultures of Dispute Resolution* (2007) at 336.

²⁸³ Boulle and Rycroft *op cit* note 239 at 53-54.

²⁸⁴ *Op cit* note.

²⁸⁵ Rules Board for Courts Law Act 107 of 1985.

of court rules. The planned management system favours mediation technique over litigation.

Rule 3 (1) of the Court-Annexed Mediation Rules²⁸⁶ provides that a dispute can be referred to mediation prior to commencement of litigation or if after commencement but before judgment is pronounced. It is also provided that the judicial officer has the discretion to refer the dispute to mediation even after commencement of litigation but on good cause. In terms of rule 4 (4) of the Court-Annexed Mediation Rules the dispute can only be referred to mediation after conclusion of an agreement to that effect. In terms of rule 6 (1) of the Court-Annexed Mediation Rules any party to the dispute has the discretion to refer the matter to mediation at any stage in writing prior to trial. Rule 10 provides that parties must draft a settlement agreement, if an agreement is reached. The rules seem to indirectly obligate parties to attempt to reach a settlement. The process of mediation can be terminated at any stage prior to settlement agreement. However, once the settlement agreement is reached such will be enforceable, as it will be legally binding.

Rule 13 (1) of the Court-Annexed Mediation Rules provides that in the mediation proceedings parties may be represented by legal representatives. The participation of lawyers in mediation should be vindicated based on best interest of their clients' rights and this need not take into account the interest of the other party. Hence, the essence of legal representatives in mediation would be primarily to provide proper counselling to their clients with regard to their interest, as well as rights and obligations, depending with nature of the case. In terms of the Court-Annexed Mediation Rules, the parties do not waive their rights to litigation, but are suspended and are only to be enforced if mediation does not result in settlement. Furthermore, the integration of mediation with court processes means any disclosures made during mediation should not be prejudicial in subsequent court trial.

Earlier drafts of the Rules did not limit mediation to Magistrate Court matters, and the omission of High Court matters from the rules is to be regretted. There is no justifiable reason why Court-Annexed Mediation system which gambles mediation over litigation should not be adopted and applied equally to High Courts. Jordaan writes that people often end up in litigation over issues that could easily have

²⁸⁶ Court-annexed Mediation Rules of the Magistrates' courts.

been resolved through mediation.²⁸⁷ Hence, with court-based mediation officially becoming part of the civil justice system, the courts will have even greater justification for its usage.²⁸⁸ Hence, the Rules Board should also exercise its powers to enact rules for mediation that are applicable to High Courts, to tackle medical negligence disputes. The limitation of mediation to Magistrates Courts has the consequence that medical negligence disputes with claims amounting to more than R300 000 will be excluded as they will be beyond the Magistrates Courts jurisdiction.²⁸⁹ In principle, the integration of mediation and litigation should be equally extended to High Courts, to counter the challenges brought about medical litigation.

In addressing the question whether mediation should be made compulsory the imposition of penal fee is indicative of the indirect compulsory nature of mediation.²⁹⁰ This will enhance disputes to be resolved through settlement talks during mediation. However, Boulle and Rycroft argue that ‘mandatory mediation’, in which parties are compelled to participate, may undermine the integrity of mediation.²⁹¹ They say this because rules of mediation provide for voluntary mediation, in which both parties’ consent is required. However, voluntary participation prevents parties from taking the process as a mere formality without the intention to settle but as a bridge to litigation. It is submitted that compulsory mediation will make the objective mediation ineffective.

Why Mediation is preferable

Mediation is preferable because it is regarded as an informal, private, voluntary, and confidential process in which a neutral mediator assists the disputants to negotiate their differences and craft a mutually acceptable resolution to their

²⁸⁷ B Jordaan ‘The potential of court-based mediation’ 2012 57 *de Rebus- South African Attorneys Journal* 18.

²⁸⁸ Jordaan op cit note 18.

²⁸⁹ Magistrate’s Courts Act 32 of 1944: as amended by Jurisdiction of Regional Courts Amendment Act 32 of 2008; “Regional courts get powers to deal with civil cases” Department of Justice and Constitutional Development; available at http://www.justice.gov.za/docs/articles/20100810_reg-courts_dailysun_ad.pdf;

(accessed 01 September 2013).

²⁹⁰ A Streeter-Schaefer, A Holly ‘Look at Court Mandated Civil Mediation’ (2001) 49 *Drake Law Review*.

²⁹¹ Boulle and Rycroft op cit note 239 at 14.

dispute.²⁹² Mediation is based on three core principles: party autonomy; informed decision making; and confidentiality. Such make mediation superior to litigation. Furthermore, the participants may end the mediation at any time, before reaching a settlement agreement without adverse consequences.²⁹³

The advantageous nature of mediation in resolving medical negligence conflicts are that the ongoing doctor-patient relationship is preserved. The patient needs the doctor in the future, and this encourages respect and cooperative association. It is possible to re-establish a positive relationship between the parties once the dispute is resolved.²⁹⁴ Hence, whereas litigation can destroy relationship between the patient and the doctor, mediation allows the preservation of such a relationship.²⁹⁵ Additionally, Lee writes that mediation of medical negligence is desirable as it diverts the focus of the dispute away from rights, winners, and losers.²⁹⁶ Mediation is preferable because it will focus on the human side of a dispute, giving a chance for conciliation and restoration of relationships, an opportunity for healing,²⁹⁷ and an opportunity for a cost-effective and timely resolution.²⁹⁸ It is argued therefore that the mediation of medical negligence disputes is equivalent to the healing function of medicine compared to litigation.²⁹⁹ This means in medical negligence cases, resolutions are found in the hearts, minds, and interests of the participants.³⁰⁰ Furthermore it should be noted that mediation allows both the doctor and patient to examine the underlying conflict through direct communication in an attempt to satisfy underlying non-monetary needs and interests

²⁹² CB Liebman and CS Hyman 'A Mediation Skills Model To Manage Disclosure Of Errors And Adverse Events To Patients' (2004) 23:4 *Health Affairs* at 22-32.

²⁹³ Liebman and Hyman op cit note 292 at 22-32.

²⁹⁴ CB Lynch, A Coker and JA Dua 'A clinical analysis of 500 medico-legal claims evaluating the causes and assessing the potential benefit of alternative dispute resolution' (1996) 103 *International Journal of Obstetrics and Gynaecology* at 1236-1242.

²⁹⁵ RL Gitchell and A Plattner ibid at 424-426; F Yee 'Mandatory Mediation: The Extra Dose Needed to Cure the Medical Malpractice Crisis' (2005-2006) 7 *Cardozo Journal of Conflict Resolution* at 393; E Galton ibid.

²⁹⁶ Yee op cit note 295 at 393.

²⁹⁷ NC Meruelo 'Mediation and Medical Malpractice: The Need to Understand Why Patients Sue and A Proposal For a Specific Model of Mediation' (2008) 29:3 *Journal of Legal Medicine* at 292.

²⁹⁸ Meruelo op cit note 297; F Yee ibid at 417.

²⁹⁹ Yee op cite note at 321.

³⁰⁰ Galton op cit note 295.

of the parties.³⁰¹ Medical negligence litigation is undesirable as it has received so many problems including the high emotional and financial costs to the litigants, the detrimental effect on the doctor-patient relationship, and the inability of tort litigation to deter doctors' negligence.³⁰² It is submitted that such problems can be alleviated by the use of mediation in medical negligence disputes.

The use of mediation in medical negligence disputes results in a potentially speedier settlement being reached. Hence, it saves a lot of time and costs³⁰³ that is spent in litigation and avoids postponement and the emotional strain encountered by parties in litigation. As far as settlement is concerned, Lynch, Coker and Dua argue that mediation in medical negligence does not allow the imposition of settlement on either party.³⁰⁴ In addition, in reaching a mutual settlement, the parties have access to the services of experienced experts who can assist their negotiation to reach a quick settlement.³⁰⁵ Furthermore, it is submitted that mediation in medical negligence disputes reduces the amount of discovery, produces emotional and financial savings for both sides. Moreover, the amount of information needed for mediation is not the same as that needed for trial, as it justifies the restriction of discovery in certain cases.³⁰⁶ Gold writes that mediation is preferable because it encourages parties to be emotionally honest to exclusion of anxiety and ego.³⁰⁷ It is therefore, submitted that the use of mediation in medical negligence cases will significantly reduce time, financial and emotional strains associated with litigation.

Yee writes that litigation is not the best option for resolving medical negligence disputes, because larger portion of the compensation awarded never

³⁰¹ A McMullen 'Mediation and Medical Malpractice Disputes: Potential Obstacles in the Traditional Lawyer's Perspective' (1990) 2 *Journal of Dispute Resolution*.

³⁰² S Forehand 'Helping the Medicine GO Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation' (1998-1999) 14 *Ohio St. J. on Disp. Resol.*

³⁰³ Forehand op cit note 302.

³⁰⁴ Lynch, Coker and Dua op cit note 294 at 1236-1242.

³⁰⁵ Ibid.

³⁰⁶ CS Hyman and CB Schechter 'Mediating Medical Malpractice Lawsuits against Hospitals: New York City's Pilot Project' (2006) 25:5 *Health Affairs* at 1394-1399.

³⁰⁷ L Gold 'Influencing Unconscious Influences: The Healing Dimension of Mediation' (1993) 11:1 *Mediation Quarterly* at 55-65.

reaches the patient.³⁰⁸ For instance, 50% of the compensation is consumed by the accumulation of attorney contingent fees, expert witness costs, court costs and other “overhead” costs.³⁰⁹ This means that under litigation, patients do not necessarily reap the benefits of the awarded compensation. The other advantage is that mediation is not hampered by procedural and substantive rules which dominate the adversarial process. This allows the participants to explore the underlying needs and desires of the other party and any other community interests which may be involved.³¹⁰ Therefore, the use of mediation in medical negligence will avoid the delay in resolving medical malpractice disputes which is associated with litigating such claims in the court system, especially in highly populated urban areas.³¹¹

Besides the monetary compensation, mediation also offers the doctor the opportunity to apologize to the patient, thus takes into account anger and emotional hurts of the patient.³¹² This means that mediation allows for the needs of all parties to be identified, acknowledged, and respected.³¹³ Hence, parties, have the opportunity for conciliation and closure as they are able to express their rage and regret.³¹⁴ Mediation allows the emotional nature of these needs to be met because it has a flexible scope, process and outcome that can be used to emphasize a patient’s emotional concerns and facilitate discussion and communication of these concerns.³¹⁵ In addition, because the patient is the only one who can receive and accept an apology, a physician may see mediation as an opportunity to be absolved for an error and move on with life.³¹⁶ Yee argues that litigation fuels anger and does not carter for emotional closure. This means that mediation in medical negligence is preferable because it allows both parties to escape the psychological consequence of

³⁰⁸ Yee op cit note at 393.

³⁰⁹ Ibid.

³¹⁰ McMullen op cit note 301.

³¹¹ McMullen ibid.

³¹² AJ Kellett ‘Healing Angry Wounds: The Roles of Apology and Mediation in Disputes between Physicians and Patients’(1987) 111 *Mo. J. Dispute Resolution*; Meruelo op cite note at 291.

³¹³ Lynch, Coker and Dua op cit note at 1236–1242.

³¹⁴ Galton op cit note; Liebman and Hyman op cit note 292 at 22-32.

³¹⁵ Meruelo op cite note.

³¹⁶ Ibid.

protracted litigation.³¹⁷ Henceforth, mediation provides a party with the opportunity to consider non-monetary remedies, in addition to money. This is a significant distinguishing feature that makes mediation superior to litigation in resolving medical negligence disputes. Often the non-monetary remedies are more emotionally significant to the parties.³¹⁸

Furthermore, mediation is advantageous because the outcome focuses on future patient safety, in which the interest of the injured individual is brought closer to the public interest of preventing future injuries.³¹⁹ The essence of mediation in medical negligence is that it creates no fault environment, which makes mediation more efficient vis-à-vis litigation.³²⁰ Hence, if mediation is used for medical negligence disputes it can be private, integrative, and nonjudgmental. Therefore, it provides disputants with the opportunity to address the source and the consequence of the immediate problem.³²¹

One of the significant benefits of mediation in medical negligence is that it allows disputants to have direct communication; hence patients are able to have a priceless and unique perception on the medical error and error resolution.³²² It is during direct communication by which mediation induces human values of trust, honest, caring, and respect, while emphasizing similarities between the parties rather than their differences.³²³ Farber and White argue that mediation in medical negligence encourages disputants to resolve cases by providing them with a common external evaluation of the claimant, which increases the likelihood of both sides reaching a mutual agreement.³²⁴ Hence, mediation allows parties to negotiate for

³¹⁷ Yee op cite note.

³¹⁸ Hyman and Schechter op cit note 306 at 1394-1399.

³¹⁹ EA Dauer and LJ Marcus 'Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement' (1997) 60:1 *Law and Contemporary Problems*; NC Meruelo ibid at 291.

³²⁰ Dauer and Marcus op cit note 319 at 186.

³²¹ Ibid at 199.

³²² Ibid.

³²³ Ibid at 373-375; Meruelo op cit note at 291; Gold op cit note 307.

³²⁴ HS Farber and MJ White 'Medical Malpractice: An Empirical Examination of the Litigation Process' *NBER Working Paper* No. 3428 Issued in September 1990, available on <http://www.nber.org/papers/w3428>, (accessed 01 September 2013).

their own settlement, in which the scope of issues that can be raised is extensive and so are the settlement options.

Mediation is desirable for medical negligence disputes in High Courts because the decision making authority is confined to the parties. Mediation is different from litigation and arbitration in that the decision is not vested in unknown judge,³²⁵ but rather it involves party control.³²⁶ As a result mediation is preferable because the proceedings are conducted in a way that allows parties to be in control of their own position compared to litigation system.³²⁷

According to Gitchell and Plattner mediation is favorable, because the legal system when resolving disputes focuses on the rights and legal obligations of the parties, whilst, mediation focuses on the underlying concerns or interests and needs of the parties.³²⁸ This means that once the needs and interests are discussed frankly and honestly, it will enhance trust between disputants. Additionally, mediation of medical negligence allows for the use of private sessions in which discussed issues remain confidential, unless agreed otherwise, to generate various options.³²⁹ Gitchell and Plattner point out that medical negligence disputes would require mediators who understand the complexities of medical and surgical protocols.³³⁰

In the mediation of medical negligence disputes, confidentiality is an essential ingredient for timely resolution.³³¹ Because if the parties trust that statements made during the mediation are kept confidential and not exposed to any third party, it will enhance the integrity and efficacy of the process will be maintained.³³² The fact that mediation communications are confidential makes it more open, and less strategic conversations possible because parties need not to fear that what they say will come back to haunt them in a la

³²⁵ Gitchell and Plattner op cit note 295 at 421.

³²⁶ Ibid.

³²⁷ CB Lynch, A Coker and JA Dua op cit note.

³²⁸ Ibid.

³²⁹ Ibid; J Joubert "Pilot in our courts set to herald a new dawn for mediation in SA": Sunday Argus, 18 March 2012.

³³⁰ Op cite note.

³³¹ Ibid.

³³² Yee op cite note.

ter proceeding.³³³ If mediation fails, the aggrieved party may invoke right to pursue the legal process. However, this will be done without prejudice.³³⁴

Furthermore, mediation of medical negligence allows consideration of cases that attorneys may refuse to take due to unlikely settlement being awarded vis-à-vis the medical error involved. With mediation, even the poor without financial determination will be able to use it.³³⁵ Mediation of medical negligence disputes facilitate disclosure conversation in which the doctor will be able to participate in difficult conversations, by sharing information, and remaining non-defensive ineffective listeners.³³⁶ This means that the indigent patient's interest is also considered in the mediation of medical negligence.

Another important possible benefit of mediation to doctors is that they may learn a valuable lesson by experiencing a mistake or claim of a mistake from the patient's perspective, by sitting in the mediation and listening to the patient's story.³³⁷ It is submitted that mediation in medical negligence may teach the doctors how to improve relationships with other patients, avoid making similar mistakes, and improve practice by being able to make those constructive changes that become apparent after the mediation experience.³³⁸ Moreover, mediation can provide a setting in which doctors, hospital representatives, and patients or family members can offer and request information.³³⁹ This means that in medical negligence disputes the claimant may gain information about the complexities and uncertainties of medical care and about exactly what happened to his or her loved one.³⁴⁰

Lastly, it is submitted that mediation is a win-win situation decided by the parties themselves. This means that if mediation fails and the parties do decide to

³³³ Liebman and Hyman *ibid* 292 at 22-32.

³³⁴ Lynch, Coker and Dua *op cit* note.

³³⁵ Meruelo *op cit* note.

³³⁶ Liebman and Hyman *op cit* note. The ability to listen by showing concern and care to the patient's story is a skill that can be learned by the doctor.

³³⁷ Meruelo *op cit* note.

³³⁸ *Ibid*.

³³⁹ Liebman and Hyman *op cit* note at 22-32.

³⁴⁰ *Ibid*.

litigate, the process of mediation would have already clarified many issues, and created opportunities for the parties to realize arguments which they could present during litigation.³⁴¹ However, Gitchell and Plattner write that mediation enables parties to deal with the issues they believe to be important; as opposed to giving the attorneys “carte blanche” to argue the legal merits.³⁴² Mediation also allows for the establishment of a medical screening panel that will evaluate evidence to determine whether or not there was medical negligence.³⁴³ This further endorses mediation as an ideal option vis-à-vis litigation as it will save time and cost. In conclusion, mediation has a significant number of advantages that will benefit both the patient and the doctor in a medical negligence dispute, compared to litigation.

Ubuntu and Mediation

Mediation should be guided by the rationale of Ubuntu, in which emotions, anxiety, hope, fear, excitement and remorse are appreciated.³⁴⁴ Ubuntu focuses on the humanness of people. ‘We are what we are because of others’. It emphasizes the importance of relations with each other in the community. According to Tutu, ‘a person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, based from a proper self-assurance that comes from knowing that he or she belongs in a greater whole and is diminished when others are humiliated or diminished...’.³⁴⁵ Tutu writes that as human beings we cannot exist in isolation from others but we are interconnected, in finding common ground to human differences. In the case of *Afri-Forum and Another v Malema and Others*³⁴⁶ Judge Colin Lamont referred to the definition of Ubuntu as a recognised source of law within the background of strained or broken relationships among individuals and communities. Ubuntu can enable parties to medical negligence to find solution in mediation, by shifting away from the adversarial or litigation which is more confrontational to mediation which strengthens relationships between parties.

³⁴¹ Gitchell and Plattner op cite note at 424-426.

³⁴² Ibid.

³⁴³ EF Oakley ‘The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation’ (2004-2005) 21 *Georgia State University Law Review* at 993.

³⁴⁴ P Mzamo *Building competitive advantage from ubuntu: Management lessons from South Africa* (2001).

³⁴⁵ D Tutu *No Future without Forgiveness* (1999).

³⁴⁶ *Afri-Forum and Another v Malema and Others* (20968/2010) [2011] ZAEQC 2; 2011 (6) SA 240.

In conclusion, the rules for mandatory mediation in civil disputes will result in tackling of medical negligence cases within reasonable time through mutual a beneficial settlement by parties, in which mediation is a viable option to use for medical negligence disputes compared to litigation.

Limitations of mediation

Although mediation is preferable compared to litigation, it is submitted that such is not immune to various drawbacks. One of the limitations is that since the mediation process is non-binding by its nature, the lack of enforcement power or “decisions” weakens the image of the effectiveness of the mediation process.³⁴⁷

The most inescapable problem of mediation in medical negligence is when one of the disputants drags its feet in attempting to resolve the dispute.³⁴⁸ This is mostly done by the defendant who knows that the plaintiff will probably not be able to sustain protracted litigation. In addition, the procedure of reporting on settlement information can negatively affect the doctor’s good standing with his peers and patients.³⁴⁹ This means that doctors will be forced to take the risk of winning through litigation than trying mediation because of the pain of a generally punitive reporting system.

In addition, the other problem of mediation is that lawyers may hold many misconceptions about mediation's effectiveness in medical negligence. Some of the common misconceptions are that:³⁵⁰ (i) patients are not as generously compensated in mediation as they are in litigation,³⁵¹ (ii) patients will be intimidated into prematurely settling commendable claims during mediation,³⁵² and (iii) mediation simply prolongs the dispute process by delaying the real resolution process-litigation.³⁵³

³⁴⁷ Forehand op cit note 302; CB Liebman and CS Hyman op cite note.

³⁴⁸ Ibid.

³⁴⁹ Meruelo op cite note.

³⁵⁰ Ibid.

³⁵¹ Ibid.

³⁵² Ibid.

³⁵³ Ibid.

Lawyers can prevent mediation to achieve its potential for flexibility and enhancing relationships between parties, through direct communication.³⁵⁴ When lawyers inappropriately impose an adversarial based approach on their clients it will act as a barrier for effective mediation.³⁵⁵ In addition, the lawyers' desire to receive more fees from litigation than mediation acts as an obstacle for mediation. Hence, they will see parties as adversaries in a win or lose situation, in which disputes can only be resolved through the application of law. Such jurisprudence is against the assumptions upon which mediation is based.

In medical negligence, lawyers transform the doctor-patient relation into a lawsuit by focusing on sensitivity of the injury and the cause of action rather than the underlying needs of emotions of the parties.³⁵⁶ This will make mediation unproductive in resolving medical negligence disputes. This means that the inclusion of lawyers in medical negligence comes with challenges. In addition, given the complexities that characterize medical negligence, lay person may not be able to understand complex medical issues to reach a decision. On the other hand, the lawyers fear losing trust from their clients if they introduce them to mediation instead of the court system.³⁵⁷ Hence, the fear of losing trust may be a factor that inhibits the use of mediation in medical negligence cases. Furthermore, although confidentiality is a significant element for mediation, it is submitted that it can be tempered with, if the other party does not perform or seeks judicial review. Rycroft argues that the actual content of a settlement agreement can be impacted by law and public policy in different ways.³⁵⁸ This makes mediation undesirable for medical negligence disputes. The author further writes that ethics maybe compromised in that some tactics used in negotiation such as deception may have negative effect on relationships.³⁵⁹ This is more complex in a multi-cultural context where bribe may be seen as a norm.³⁶⁰

³⁵⁴ McMullen op cite note.

³⁵⁵ McMullen op cit note.

³⁵⁶ Ibid.

³⁵⁷ Ibid at 377.

³⁵⁸ Rycroft op cit note at 188 to 190.

³⁵⁹ Ibid.

³⁶⁰ Rycroft op cit note.

Lawyers lack education about mediation and the required skills and techniques required for a successful mediation process.³⁶¹ The lack of funding for the training of mediators may also be an inhibiting factor for the use of mediation in resolving medical negligence disputes. Furthermore, the inability of mediators to consider cultural differences during mediation process poses some of the barriers in the effectiveness of mediation.³⁶² The other factor is that parties to the dispute may have different perceptions of fairness of the outcome. Rycroft writes that our law does not insist in good faith for reaching a settlement.³⁶³ The author argues that mediation may result in an abuse of the duty to bargain in good faith due to the use of bad tactics such as wasting time and money to discourage parties who cannot afford litigation.³⁶⁴ This means that if one of the parties to the mediation bargains in bad faith, the purpose of mediation may become ineffective.

The inequalities and imbalances of power in mediation can be a barrier for effective mediation in medical negligence disputes.³⁶⁵ In addition, the lack of education about the availability and benefits of the use of mediation in medical negligence disputes can be one of the hurdles for its usage.³⁶⁶ Furthermore, non-disclosure in negotiation can also be a factor that limits the effectiveness of mediation in medical negligence disputes.³⁶⁷ Lastly, the excessive monetary and emotional costs which characterize medical negligence disputes often result in parties finding it difficult to compromise.³⁶⁸ In conclusion, mediation is desirable compared to litigation. However, various factors inhibit the use of mediation in tackling medical negligence disputes.

³⁶¹ McMullen *ibid.*

³⁶² MR Lebed and McCauley 'Mediation within the Health Care Industry: Hurdles and Opportunities' (2005) 21 *Georgia State University Law Review*.

³⁶³ Rycroft *op cit* note at 193.

³⁶⁴ Rycroft *op cite* note.

³⁶⁵ Lebed and McCauley *op cit* note 362.

³⁶⁶ *Ibid.*

³⁶⁷ Rycroft *op cit* note.

³⁶⁸ McMullen *ibid.*

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CHAPTER 4: HOW TO MAKE MEDIATION EFFECTIVE

Introduction

For mediation to work, it will be imperative to consider viable options that will make complex disputes between the patient and hospital resolved in a time-efficient manner. The expeditious and inexpensive nature of mediation can be undermined, if disputants approach mediation with an adversarial mentality. This will promote impasse and destabilize the mediation process. Mediation remains a viable alternative to litigation, only if the barriers to effective mediation are eliminated. In this chapter tactics and strategies that can be adopted to mitigate impediments to effective mediation between the patient and hospital will be considered.

Strategies for mediation

Appointment of the mediator

Some disputants have a tendency to quarrel over the appointment of a mediator. In medical negligence disputes parties should be given the room to choose their own mediator. To allow mediation to be fast and inexpensive, Shore writes that stalemate over the selection of a mediator can be avoided if one party allows the other party to pick the mediator from an agreed list of mediators.³⁶⁹ This allows parties to develop trust and cooperation in the mediation process, in which the mediator will be perceived as impartial and neutral. Hence, due to the essence of neutrality a mediator cannot be imposed upon the parties.³⁷⁰ The acceptance of a mediator chosen by either the patient or hospital is not a great risk because the role of the mediator is not to make a binding decision for the parties.³⁷¹ Therefore, prior to commencement of the mediation process the patient and hospital ought to agree on a mediator they both appreciate and respect. It is also possible to reach agreement on the method of appointing a mediator in anticipation of a dispute arising, most often leaving the choice of a mediator to a recognized ADR organization such as Tokiso, Equilaw and Conflict Dynamics. An agreement is more likely before the dispute

³⁶⁹ R Shore *Four Tricks That Makes Mediation Work* 2012, available on <http://www.forbes.com/sites/forbesleadershipforum>, [accessed on 18 July 2013].

³⁷⁰ A Rycroft *Mediation of Human Rights Disputes*, (1993) *de Rebus* 211 at 290.

³⁷¹ Shore op cit note 369.

arises, at the time of the patient's registration at the hospital, when signing indemnities and other contractual arrangements.

Adversarial and interest based strategies

Some scholars argue that adversarial and interest based strategies must be balanced in mediation.³⁷² Adversarial strategy is used where an ongoing relationship is not anticipated and important.³⁷³ An adversarial approach should not be used as the sole strategy in mediation, otherwise it will increase the chances of impasse; it does not promote the development of creative options by parties.³⁷⁴ In the mediation process, parties should be in a position to balance concerns, in the context of the perceived conflict, by considering the situation of the other party.³⁷⁵ Both the patient and hospital's interests must be identified and addressed to become cooperative problem solvers rather than adversaries.³⁷⁶ On one hand, the hospital should be prepared to acknowledge the patient's feelings by considering compensation for the injury, explanation and apology to the patient. On the other hand, the patient should be in a position to consider not only the hospital's financial situation but also the doctor's expression of regret and explanation as to why something was done the way it was.³⁷⁷

Focus on interests and not positions

To avoid impasse, disputants in mediation should be willing to make concessions to encourage a long term relationship. According to Fisher and Ury parties negotiating in mediation should focus on the interests and not the positions of the parties.³⁷⁸ It is the responsibility of the mediator to encourage parties to make offers and explore interests that satisfy the needs of both parties. This can be achieved when the mediator enables parties to separate the people from the problem,

³⁷² RP Buckley 'Adversarial Bargaining: The Neglected Aspect of Negotiation' (2001) 75 *Australian Law Journal*,

³⁷³ Buckley op cit note 372.

³⁷⁴ Ibid.

³⁷⁵ R Shell *BARGAINING FOR ADVANTAGE: Negotiation for reasonable People* (1999) at 128-129.

³⁷⁶ T Belak *The Use of Mediation in the Patient Complaint Process* (2003), available on <http://www.mediate.com/articles/belak3.cfm>, accessed 23 September 2013.

³⁷⁷ T Bogdanoski 'Medical negligence dispute resolution: A role for facilitative mediation and principled negotiation?' (2009) 20 *ADRJ* at 80-83.

³⁷⁸ Fisher and Ury op cit note at 42.

by cooling anger and personal attacks and maintaining an environment that allows parties to negotiate in trust during the mediation.³⁷⁹ This will assist in making the mediation work and diluting distrust between the parties. Interest is defined as an underlying concern which pushed the party into taking a particular position and the need is a basic necessity to ensure quality of life. Therefore for mediation to work, both the patient and hospital should focus on their underlying concerns, facilitated in a manner that allows parties to reconcile their interests and not positions.³⁸⁰ To avoid impediments during mediation, the mediator should consider leaving hard issues to the later stages of the mediation.³⁸¹ The strategy of starting with flexible issues creates a momentum for settlement by eliminating any barriers.³⁸² The mediator should assist and encourage parties to be more accommodative to the needs and interest of the other side. It is argued that this mediation approach is very effective, if both parties concede that they are partially responsible for the problem and can easily resort to compromise.³⁸³ Therefore, it enhances an effective mediation process. For example in mediation of medical negligence claims between the patient and hospital, the hospital's interest would be to safeguard its reputation and avoid staff shortage. To avoid staff shortage and protracted waiting list, South African public hospitals will be in a position to compromise, in order to promote the value of continuity of relations between patient and doctor.

Communication

For mediation to work, the mediator must enhance effective communication and be in a position to understand the issues of the parties so as to give logical guide.³⁸⁴ It is imperative to avoid misinterpretation, especially where parties speak different languages.³⁸⁵ For effective mediation, where language is a barrier, an interpreter should be used. Furthermore, the mediator should always be in a position

³⁷⁹ Ibid.

³⁸⁰ Fisher and Ury at 49 -57.

³⁸¹ Shore op cit note.

³⁸² Ibid.

³⁸³ RS Haydock 'CIVIL JUSTICE AND DISPUTE RESOLUTION IN THE TWENTY-FIRST CENTURY: MEDIATION AND ARBITRATION NOW AND FOR THE FUTURE' (2000)27 *William Mitchel Law Review* at 745.

³⁸⁴ Fisher and Ury op cit note.

³⁸⁵ Ibid.

to clarify each party's version of dispute and the interest sought, so that parties are always 'on the same page'. A practical approach is for the mediator to check her or his understanding by paraphrasing a party's statement and get agreement that it is understood correctly. This technique, together with the use of open-ended questions, gives the parties the assurance that they have been understood.

Persuasive

In mediation proficiency in the art of persuasion plays a key role in the parties' ability to reach a mutual settlement. Persuasion is defined as an attempt to change beliefs and perceptions.³⁸⁶ Wade suggests that persuasion is an effective tool in mediation because insights and frameworks are fragile and tentative.³⁸⁷ In mediation, the mediator must be able to evaluate the circumstances, issues and interests in order to facilitate and provide options that parties can pursue, in the event of stalemate.³⁸⁸

Cooperation

One of the strategies of mediation is the ability of the disputants to co-operate by providing solutions that will meet the interests of the other party. Fisher and Ury argue that for effective negotiation in mediation, parties need to consider ways that satisfy the interest of both disputants.³⁸⁹ Parties can cooperate with each other during mediation by brainstorming options together.³⁹⁰ Mediation can be made effective, if parties cooperate by identifying their differences in interests, risks and beliefs.³⁹¹ This allows both disputants to attain mutual gains and prompt early settlement.

Multiparty negotiation skills

Mediation can be complex and ineffective where negotiations involve a number of parties, in which many and complex issues are to be resolved. Some scholars suggest that mediation of multilateral negotiation requires the interests of all

³⁸⁶ J Wade 'PERSUASION IN NEGOTIATION AND MEDIATION' (2008) *Dispute Resolution Centre Newsletter*.

³⁸⁷ Wade op cit note.

³⁸⁸ Ibid.

³⁸⁹ Fisher and Ury op cit note at 59-69.

³⁹⁰ Ibid.

³⁹¹ Ibid.

participants to be adjusted according to similarities.³⁹² In medical negligence disputes, the mediator should conduct multiparty negotiation that involves multilateral processes to reach mutually acceptable agreement for all parties.³⁹³ For instance prior to negotiation, during the pre-negotiation stage, the mediator should allow planning, formulation of differentiation of roles and identification of the main actors among the participants in the disputes.³⁹⁴ This will be facilitated by creating an environment that allows parties to naturally form coalition with regard to common interests.³⁹⁵

Suspension of court proceedings

Court-annexed mediation can work, if courts support the mediation process by ordering a stay [suspension] of court proceedings brought in breach of a valid mediation agreement.³⁹⁶ The stay of court proceedings would enforce the use of and respect for mediation.³⁹⁷ For mediation to work in a medical negligence dispute between the patient and hospital, the role of the court should be limited to the failure of the mediation in finding a resolution.

Voluntariness

Voluntariness is an essential principle for the mediation process to be successful. However, in many cases, for example under CCMA this is not so because the defendant is forced to conciliation. The mediator must ensure that parties are voluntarily participating in the mediation process from the beginning to the end.³⁹⁸ Haydock suggests that mediation can work if parties voluntarily mediate not because they want to but because they have to.³⁹⁹ Syverud argues that the likely outcome is that the effectiveness and efficiency of mediation will automatically result in the

³⁹² S Touval 'Multilateral Negotiation: An Analytical Approach' (1989) *Negotiation Journal* April.

³⁹³ Touval op cit note.

³⁹⁴ Ibid.

³⁹⁵ Ibid.

³⁹⁶ JG Mowatt 'Some Thoughts on A Mediation Profession' (1993) 110 *South African Law Journal*.

³⁹⁷ Mowatt op cit note.

³⁹⁸ CW Moore *The Mediation Process: Practical Strategies for Resolving Conflict* (2003).

³⁹⁹ Haydock op cit note 383 at 745.

abandonment of litigation.⁴⁰⁰ The mediator can make use of a private caucus to enable parties to compromise their positions and find common ground.⁴⁰¹ In medical negligence disputes parties may willingly use a private caucus whenever there is an impasse in the mediation process.

In conclusion, it is an essential strategy for parties to be allowed to voluntarily agree to mediation process in an attempt to resolve medical negligence disputes. Thereafter, burden would be upon the mediator to facilitate mediation in a manner that is effective and efficient for a mutually acceptable resolution to be adopted. To make mediation work in a dispute between the patient and doctor, the mediator should demonstrate abilities in people management skill, such as the ability to know when to ask questions for clarifications, and the ability to listen responsively to all parties' versions in a way that reflects impartiality.

Furthermore, the mediator should be equipped with the ability to manage the mediation process by creating a favourable environment for parties to open up. The mediator ought to be in control of the mediation process in a way which encourages parties to compromise their positions and exchange offers. Effective mediation may then result in the drafting of a settlement agreement endorsed by both parties. Lastly, to make mediation in medical negligence disputes effective the mediator should be in a position to persuasively assist parties to generate options and encourage parties to focus on interest rather than positions. In mediation process, the ability of the mediator to assist parties in exploring their positions and interest in finding a solution to the problem will make mediation effective. This is contingent upon the mediator's effective communication.

⁴⁰⁰ KD Syverud 'ADR and The decline of The American Civil Jury' (1997) 44 *UCLA LAW REVIEW* 1935.

⁴⁰¹ Boulle and Rycroft op cite note.

CHAPTER 5: COMPARATIVE ANALYSIS OF USA AND SA MEDIATION SYSTEMS

Introduction

The nature of ADR in most judicial systems is historically rooted in USA legal system,⁴⁰² in which legislation was enacted for mandatory court annexed ADR at district level.⁴⁰³ In the USA negotiation is said to be 'litigotiation' because the negotiation happens in the shadow of litigation, meaning one negotiate knowing that if one does not reach settlement, the law will decide the matter.⁴⁰⁴ Therefore, negotiation is an alternative to adjudication to avoid the winner-take-all outcome of adjudication? The ADR procedures are beneficial in cutting down time and costs involved in litigation. The USA judicial system enacted legislation which provided a framework for the adoption of the Federal Court Annexed Arbitration.⁴⁰⁵ In South Africa (SA), arbitration outside of labour arbitration at the CCMA occurs in terms of the Arbitration Act,⁴⁰⁶ and it is not court-annexed arbitration as in USA. The chapter will analyse similarities and differences between USA and SA mediation systems.

Although USA was the pioneer of court-annexed mediation system, South Africa is implementing its pilot programme of court annexed mediation which is similar to USA, although it differs in some aspects.⁴⁰⁷ Since 2001, all states in the

⁴⁰² M McManus and B Silverstein 'Brief History of Alternative Dispute Resolution in the United States' (2011)1:3 *Cadmus Promoting Leadership in Thought*, available online <http://www.cadmusjournal.org>, (accessed 10 July 2013).

⁴⁰³ BS Meierhoefer *Court-Annexed Arbitration in Ten District Courts Federal Judicial Center* (1990).

⁴⁰⁴ McManus and Silverstein op cit note; G Marc '... A Settlement Judge, not a Trial Judge: Judicial Mediation in the United States' (1985) 12:1 *JOURNAL OF LAW and SOCIETY* at 1.

⁴⁰⁵ Meierhoefer op cit note.

⁴⁰⁶ South African Arbitration Act 42 of 1965.

⁴⁰⁷ South African COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS, 2013. The preamble provides that ... '... Rules Board should make rules to regulate the procedure for voluntary referral to court-annexed mediation of civil disputes, to be implemented on a pilot basis in certain courts'; E Ward 'Mandatory Court-Annexed Alternative Dispute Resolution in the United States Federal Courts: Panacea or Pandemic Symposium: Transatlantic Perspectives on Alternative Dispute Resolution' (2007) 81: 1 *St. John's Law Review*; D Peters *Court-Annexed Mediation* available on <http://usinfo.org/enus/government/branches/peters.html>, (accessed on 10 July 2013).

USA are regulated by the Uniform Mediation Act⁴⁰⁸ which provides uniform standards for conducting mediation in civil disputes. While US mediation is regulated by statute, in South Africa it is driven by rules of the courts. In this chapter, the dissertation shall compare the USA's statutory regulated mediation vis-à-vis South African mediation, as regulated by court rules in terms of the Rules Board for Courts Law Act.⁴⁰⁹ The manner in which US court-annexed mediation has being implemented will be significant in facilitating and tailoring mediation to suit South African circumstances. The essence of arbitration and mediation in the medical field is that these mechanisms expeditiously reduce the backlog of unresolved cases in medical negligence. The Chapter analyzes how best South Africa can design its ADR mechanism of mediation along USA system in tackling medical negligence disputes.

Court Annexed Arbitration

The UNCITRAL Model Law adopted by United Nations established conventional standards for arbitration, which countries could enact and align with.⁴¹⁰ It is based upon the principle that local courts should support arbitration without interfering with the arbitral process.⁴¹¹ Article 1(3)⁴¹² defines arbitration as a private method of dispute resolution, agreed upon by parties for obtaining a final and binding resolution of existing and/or future disputes. The neutrality of the place and enforceability of arbitration are key benefits of arbitration.⁴¹³ Although it is informal, it is flexible and the procedure is left to the parties to craft for themselves.⁴¹⁴

The Judicial Improvements and Access to Justice Act and Judicial Improvements Act⁴¹⁵ provided framework for the adoption of Federal Court

⁴⁰⁸ Uniform Mediation Act of 2001.

⁴⁰⁹ Rules Board for Courts Law Act 107 of 1985.

⁴¹⁰ UNCITRAL Model Law adopted by the United Nations in 1985.

⁴¹¹ UNCITRAL Model Law adopted by the United Nations in 1985; Aaron S, "International Arbitration I: Drafting an Arbitration Clause for International Commercial Contracts", *South African Journal*, (1990) at 652.

⁴¹² UNCITRAL Model Law adopted by the United Nations in 1985.

⁴¹³ SI Strong 'Research in International Commercial Arbitration: Special Skills, Special Sources' (2009) 20:2 *The American Review of International Arbitration*.

⁴¹⁴ Ibid.

⁴¹⁵ The Judicial Improvements and Access to Justice Act of 1988 and Judicial Improvements Act of 1990.

Annexed Arbitration.⁴¹⁶ Hence, the USA has Court Annexed Arbitration. The hearing is conducted by an arbitrator or panel of three arbitrators and local rules in Court Annexed Arbitration governs discovery in pre-arbitration and pre-trial motions, therefore federal rules of evidence do not apply.⁴¹⁷ At the arbitration the parties are allowed to use non-privileged evidence and hearsay.⁴¹⁸ It is submitted that arbitration can work effectively, if the cases are given effective time frame they have to be completed, parties are given opportunity to choose the arbitrator of their choice and the number of arbitrators that may hear the case. Additionally, the fees for the arbitrator and hearing costs ought to have parties' input.⁴¹⁹ In USA arbitration is mostly used for cases relating to contracts and torts, with a maximum monetary limit that could be claimed.⁴²⁰ Court Annexed Arbitration was designed to be used to resolve civil disputes between parties, based on monetary jurisdiction. The flexibility of arbitration is that parties have the autonomy to tailor the arbitral proceedings according to their interests, although parties need to prepare as they would for litigation. However, some scholars suggest that arbitration is regarded as second class justice.⁴²¹ In *Colgrove v Battin*⁴²² the Supreme Court upheld that the constitution does not deprive courts of the authority to be flexible and innovative in the face of changing times and needs. The effectiveness of court-annexed arbitration depends upon *bona fide* participation of the parties to the dispute. It is submitted that in the arbitration process, participation is meaningful if all parties concerned participate and make presentations. In the USA court has the authority to strike a party's demand for a trial in favour of arbitration.⁴²³

⁴¹⁶ Meierhoefer op cit note.

⁴¹⁷ L Bernstein 'Understanding the limits of Court-Connected ADR: A Critique of Federal Court-Annexed Arbitration Programs' (1993) 141 U. PA. L. REV. 2177-2186.

⁴¹⁸ L Bernstein *ibid*.

⁴¹⁹ Meierhoefer op cit note.

⁴²⁰ L Bernstein 'Understanding the limits of Court-Connected ADR: A Critique of Federal Court-Annexed Arbitration Programs' (1993) 141 U. PA. L. REV. 2177-2186; PF Gazda 'Arbitration: Making Court-Annexed Arbitration an Attractive Alternative in Texas' (1984) 16 *Mary's Law Journal*.

⁴²¹ Bernstein op cit note.

⁴²² *Colgrove v Battin*, 413 U.S 149 (1973).

⁴²³ Bernstein op cit note.

Court-Annexed Arbitration in the USA was evaluated in five States.⁴²⁴ The outcome showed that the pursuit of court-annexed arbitration has been regarded as useful for judicial administrators as it reduces the backlog of cases meant for litigation.⁴²⁵ In *Firelock v District Court*⁴²⁶ consent was endorsed as a prerequisite for arbitration because mandatory violates the right of access to courts as enshrined in the Constitution. It is common cause that in the USA hospitals, an arbitration agreement is presented to patients to sign and voluntarily agree to the use of arbitration first in the case of a medical negligence dispute.⁴²⁷

When compared to the USA jurisdiction, South Africa arbitration is also regulated by an Arbitration Act⁴²⁸ which is modelled on the English Arbitration Act.⁴²⁹ However, whilst the USA Arbitration law is fundamentally influenced by UNCITRAL Model Law,⁴³⁰ the difference between USA and South Africa is that South Africa Arbitration law is based not based on Model Law and does not have Court-Annexed Arbitration.

South Africa and the USA derive the same advantages offered by arbitration compared to litigation as it is a more expeditious and cost effective technique to resolve disputes. However, it can be argued that arbitration is more expensive because one has to pay for lawyers and the arbitrator whereas the cost of a judge is borne by the state. Article 16⁴³¹ deals with the competence of the arbitral tribunal in dealing with its own jurisdiction: In South Africa such is supported by the decision

⁴²⁴ KO Boyum Afterword: Does Court-Annexed Arbitration "Work"? (1991) *The Justice System Journal* at 244-247. Evaluation of court-annexed arbitration in Georgia, North Carolina, New Jersey, Hawaii and Colorado concluded the reduction in system costs.

⁴²⁵ KO Boyum Afterword: Does Court-Annexed Arbitration "Work"? (1991) *The Justice System Journal* at 244-247.

⁴²⁶ *Firelock v District Court*, 776 P.2d 1090 (Colo. 1089) (en banc).

⁴²⁷ I Ladimer, C Joel, B Solomon and M Mulvihill 'Experience in medical malpractice arbitration' (2009) 2:4 *Journal of Legal Medicine*.

⁴²⁸ Arbitration Act 42 of 1965. Of which critics have written a lot about English Arbitration's shortcomings and that makes it undesirable to follow.

⁴²⁹ English Arbitration Act 1996.

⁴³⁰ S Aaron "International Arbitration I: Drafting an Arbitration Clause for International Commercial Contracts", (1990) *South African Journal*.

⁴³¹ UNCITRAL Model Law adopted by the United Nations in 1985.

*Van Heerden v Sentrale Kunsmis Korporasie (Edms) Bpk.*⁴³² However, it is submitted that in South Africa the competency of an arbitral tribunal to rule on its own jurisdiction does not mean that its decision should not be subjected to court control.⁴³³ Although USA requires reasoned awards to be provided,⁴³⁴ however such is not the position in South Africa.⁴³⁵ Furthermore, in South Africa the publication requirement in s 25(1) has been condemned as not necessarily observed in practice.⁴³⁶ Notwithstanding this, it is submitted that there has to be harmony between South African arbitration and Model Law as adopted by USA.⁴³⁷ South Africa's arbitration standards ought to be aligned according to the UNCITRAL Model Law.⁴³⁸ The purpose of arbitration is realizing fair resolution of disputes through an autonomous and neutral arbitral tribunal without unnecessary delay and expense. This objective is at par with that of USA Arbitration Act. For this to be achieved the arbitrator has powers to oversee the matter without delay. In South Africa the essence of privacy of the arbitration hearing, the confidentiality of the arbitral process and the award are regarded as essential principles of arbitration.⁴³⁹ Hence, arbitration is frequently used for commercial disputes in South Africa. Although confidentiality is desirable in medical negligence public interest may require full disclosure of negligence in public hospitals. Therefore, its usage will be subject to limitation.

⁴³² *Van Heerden v Sentrale Kunsmis Korporasie (Edms) Bpk* 1973 1 SA 17 (A). The court dealt with arbitration based on a contract as enforceable by the arbitral tribunal.

⁴³³ SOUTH AFRICAN LAW COMMISSION. PROJECT 94. ARBITRATION: AN INTERNATIONAL ARBITRATION ACT FOR SOUTH AFRICA. REPORT. JULY 1998 at 95 -121 available on salawreform.justice.gov.za/reports/r_prj94_july1998.pdf [accessed 25 July 2013].

⁴³⁴ TE Carbonneau 'Arbitral Justice: The Demise of Due Process in American Law' (1946) 70 *Tulane Law Review*.

⁴³⁵ *Schoch NO v Bhettay* 1974 4 SA 860 (A) 865D-E.

⁴³⁶ DW Butler 'The Recovery of Interest in Arbitration Proceedings: an Agenda for Lawmakers' (1995)

6 *Stel LR*.

⁴³⁷ MF Hoellering 'UNCITRAL Model Law on International Commercial Arbitration: The Current Developments' (1986) *The International Lawyer*.

⁴³⁸ UNCITRAL Model Law on International Commercial Arbitration of 1985; South African Law Commission (Commission) which proposes domestic Arbitration Act. The end product of this reform may materially differ from US however there is no plan for it to be annexed to court process.

⁴³⁹ S A Law Commission Arbitration: A Draft International Arbitration Act for South Africa Discussion Paper 69 1997.

As in US, it is noted that in South African features of arbitration are similar to the court of law and depend upon the ultimate power of the court for its enforcement.⁴⁴⁰ In order to be enforceable parties must reduce their agreement in writing, to arbitrate any dispute or future dispute relating to any matter specified in the agreement.⁴⁴¹ It is suggested that the shortfalls of South African Arbitration Act can be solved by the use of an arbitration agreement in which the procedure, powers and jurisdiction of the arbitrator are clarified.⁴⁴² Another similar element between US and SA is that Arbitrator's decision is final although, it can be subject to appeal.⁴⁴³ However, in South Africa arbitration can be equally expensive for the parties as they would have to bear cost of the venue, arbitrator and recording of the proceedings.⁴⁴⁴ Hence the use of a single arbitrator in the arbitral proceedings is desirable to cut down arbitration costs is a shared custom between USA and South Africa. Similarly to the USA, the use of arbitration will allow South African public hospitals to utilize its expeditious nature in providing an arbitration agreement to patients upon admission for any medical negligence dispute that may occur during operation.⁴⁴⁵ However, other unfavourable factors of arbitration are that, arbitrators have limited powers, and their awards do not bind third parties and it is a challenge for arbitration to be used in multiparty disputes.⁴⁴⁶

Court Annexed Mediation

In USA the rational for mediation stems from the fact that the process is voluntary, is associated with low costs compared to arbitration and formal litigation proceedings. In USA, the Uniform Mediation Act⁴⁴⁷ (UMA) was enacted post National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2001. On the other hand, in South Africa, the Preamble of the COURT- ANNEXED

⁴⁴⁰ M Jacobs *The Law of Arbitration in South Africa* (1977).

⁴⁴¹ Op cite note.

⁴⁴² Ibid.

⁴⁴³ DW Butler *Arbitration in South Africa - Law and Practice* (1993).

⁴⁴⁴ M Jacobs *The Law of Arbitration in South Africa* (1977).

⁴⁴⁵ S Michael and MS Pepper "Is South Africa on the verge of a medical malpractice litigation storm?" (2011) *South African Journal of Bioethics and Law*.

⁴⁴⁶ SI Strong Research in International Commercial Arbitration: Special Skills, Special Sources (2009) 20:2 *The American Review of International Arbitration*.

⁴⁴⁷ Uniform Mediation Act of 2001.

MEDIATION RULES⁴⁴⁸ provides that 6(1) of the Rules Board for Courts Law Act 107 of 1985 empowers the Rules Board for Courts of Law (Rules Board) established under section 2 of that Act to make rules for the Supreme Court of Appeal, the High Courts and the lower courts. In South Africa subsequent to the Access to Justice Conference in 2011 steps were taken to introduce court-annexed mediation into the court system⁴⁴⁹. In terms of Rule 2 (1)⁴⁵⁰ the rules apply to voluntary mediation of a dispute and in terms of rules 6 and 7⁴⁵¹ the rules are applicable in the Magistrate's Courts. Although the process adopted by USA is equally the same as embraced by South Africa, it is submitted that that the monetary jurisdiction required for South African Magistrate Courts should be considered as one of the inhibiting factors for application of mediation in medical negligence.⁴⁵²

The Uniform Mediation Act⁴⁵³ (UMA) is applicable to all types of mediations, except those relating to collective bargaining and proceedings conducted by judicial officers. This statute is applied in all USA states concerning mediation disputes. One of the components of Uniform Mediation Act⁴⁵⁴ (UMA) is that all mediation communication should be classified as confidential. Participants and non-participants must be able to engage in mediation and speak with full candour to enable the success of mediation.⁴⁵⁵ In terms of section 5 (a) of Uniform Mediation Act⁴⁵⁶ (UMA) mediation communication is confidential and privileged. It is not to be used in discovery or admission into evidence under litigation. This means that parties to mediation may refuse to disclose any prejudicial information exchanged during

⁴⁴⁸ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁴⁹ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁵⁰ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁵¹ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁵² Magistrates' Courts Amendment Act 40 of 1952; "Regional courts get powers to deal with civil cases". Department of Justice and Constitutional Development. 10 August 2010, Available on www.justice.gov.za/

[Accessed 16 July 2013].

⁴⁵³ Uniform Mediation Act of 2001.

⁴⁵⁴ Uniform Mediation Act of 2001.

⁴⁵⁵ Uniform Mediation Act of 2001.

⁴⁵⁶ Uniform Mediation Act of 2001.

mediation. If parties decide to waive such privileges, it must be reduced to writing, as parties cannot renounce such by conduct. Therefore, the Act allows parties to opt out of the confidentiality pact. Uniform Mediation Act⁴⁵⁷ (UMA) has comprehensive application which encourages parties to reach a mutual agreement by exercising their autonomy. However, the Act does not prescribe standards or qualifications for mediators, thus leaving the onus upon the parties to decide.⁴⁵⁸ The mediator nevertheless, must be able to disclose his or her qualifications if one party requests such.

Case Study of the state of Florida State⁴⁵⁹

In the state of Florida under the USA model, the mediator may meet jointly or separately with disputing parties, but does not grant a judgment over the dispute. The mediation model allows a judge to serve as a 'Judge Mediator' in any case referred for mediation, provided that the judge is not involved in the case as a presiding officer. The judicial officers are authorized by Local Rule 16 (2) (c) to issue an Order of Referral to Court-Annexed Mediation, for any case referred to them, within the framework of court calendar.⁴⁶⁰ Most successful mediation programs in USA are through statutory or rule based mandatory mediation. In Florida, the court system has mandatory mediation. According to the Florida court mediation system the judge, together with disputants determine whether the case is appropriate for referral. The Florida judicial system has a "10-day rule" that allows parties to agree on a mediator.⁴⁶¹ This ought to be carried out within 10 days after an order referring the case to mediation. Court-ordered mediation encourages parties and their legal representatives to commit as they have no alternative, except to find a solution. In

⁴⁵⁷ Uniform Mediation Act of 2001.

⁴⁵⁸ Uniform Mediation Act of 2001.

⁴⁵⁹ RB Moberly 'Ethical Standards for Court-Appointed Mediators and Florida's Mandatory Mediation Experiment' 1994 (21) *Florida State University Law Review*.

⁴⁶⁰ LOCAL RULES United States District Court for the Southern District of Florida Revised December (2011).

⁴⁶¹ LOCAL RULES United States District Court for the Southern District of Florida Revised December (2011).

most federal courts in the USA mediation has become the principal ADR process to adopt. In which the court has the power to certify and disqualify mediators.⁴⁶²

Case Study of the state of Texas⁴⁶³

In 1983, the state of Texas legislated the creation of alternative dispute resolution centres in various state districts, as a pilot programme.⁴⁶⁴ The State of Texas differs from the state of Florida in that each state has inherent powers to enact its own laws. The promulgation of the Mediation Bill was followed by the enactment of the Texas Alternative Dispute Resolution Procedure Act⁴⁶⁵ which begins with a statement that “it is the policy of the State to encourage the peaceable resolution of disputes...and early voluntary settlement pending litigation.”⁴⁶⁶ Section 154.023 of the Act⁴⁶⁷ (a) provides that mediation is “a forum which requires an impartial person to facilitate effective dialogue between disputants to promote understanding and settlement...”⁴⁶⁸ In terms of the Act, either the litigants or court can appoint a neutral third party to be the mediator.⁴⁶⁹ However, the consequence of such a procedure is not binding on the parties. Furthermore, section 154.071 of the Act requires a written mediation agreement equally enforceable as a contract. This can also be incorporated into the final judgement of the court, if the need arises for such.⁴⁷⁰ In terms of section 154.052 of the Act⁴⁷¹ mediators are required to be trained for a minimum of forty hours.⁴⁷² It is significant for the lawyers to be trained to be able to logically and comprehensively facilitate the mediation process.⁴⁷³

⁴⁶² LOCAL RULES United States District Court for the Southern District of Florida Revised December (2011).

⁴⁶³ RL Wissler ‘Court-connected mediation in general civil cases: what we know from empirical research’ (2001) 17 *Ohio St. J. Disp. Resol*

⁴⁶⁴ D Scott-Macnab ‘Mediation- Procedure of the Future’ 1989 *de Rebus* 211.

⁴⁶⁵ Texas Alternative Dispute Resolution Procedure Act of 1987.

⁴⁶⁶ Scott-Macnab op cit note.

⁴⁶⁷ Texas Alternative Dispute Resolution Procedure Act of 1987.

⁴⁶⁸ Texas Alternative Dispute Resolution Procedure Act of 1987.

⁴⁶⁹ Texas Alternative Dispute Resolution Procedure Act of 1987.

⁴⁷⁰ Ibid.

⁴⁷¹ Texas Alternative Dispute Resolution Procedure Act of 1987.

⁴⁷² C Sen Krier and C Nadig ‘1987 Alternative Dispute Procedures Act: An Overview’ (1988) 22 1 *Texas Bar Journal*.

⁴⁷³ Scott-Macnab op cit note 211 at 212.

Comparably, South Africa can tailor the same principles and techniques as entrenched in the Florida and Texas statutes to suit the South African social and economic environment. One of the material differences between USA and SA is how mediation is regulated. Whereas US law governing mediation differs from one state to another, in South Africa all national Magistrate Courts in nine provinces apply uniform court rules of mediation.⁴⁷⁴ Henceforth, South Africa mediation is regulated by court rules⁴⁷⁵ while in USA mediation is regulated by a statute,⁴⁷⁶ in which states have the prerogative to enact laws that govern mediation in their jurisdiction, which may differ in content and principle from other states in US. The significance of this difference is that in South Africa the uniformity of the mediation law brings certainty.

The role of the mediator in South Africa⁴⁷⁷ is similarly the same as in US. However, the question is who can be a mediator in SA? The difference between US and SA is that in the former, mediation can be done by the counsels of the parties to the dispute.⁴⁷⁸ In most cases, negotiation is actively mediated by a judge. The American judiciary system allows judges to participate in settlement; as a result fewer than 10 per cent of cases are tried as most of the cases are resolved by settlement.⁴⁷⁹ In terms of Local Rule 16.2 (a)⁴⁸⁰ a mediator is a certified attorney who possesses the required skills, to facilitate a mediation process. These include the ability to stimulate negotiations, analyze issues, conduct private caucuses and question perceptions, of which witness testimonies are excluded.⁴⁸¹ It is submitted that mediators must be knowledgeable in the speciality concerned, to be able to facilitate with logic and cohesion the mediation process. Furthermore, training of

⁴⁷⁴ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁷⁵ SOUTH AFRICAN COURT-ANNEXED MEDIATION RULES of the Magistrate Court.

⁴⁷⁶ Uniform Mediation Act of 2001.

⁴⁷⁷ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS, Rule 8.

⁴⁷⁸ L ROSELLE and R Wissler 'Court-Connected Mediation in General Civil Cases: What We Know from Empirical Research' (2002) 17:3 *OHIO STATE JOURNAL ON DISPUTE RESOLUTION*.

⁴⁷⁹ ROSELLE op cite note.

⁴⁸⁰ Local Rules United States District Court for the Southern District of Florida Revised 3 December 2012.

⁴⁸¹ Op cite note.

mediators should be considered as material for mediators to understand the procedure and facilitate mediation process. In medical negligence, lawyers must be assisted by co-mediators with medical knowledge to be able to negotiate compensation on behalf of their clients against public hospitals.

Even though judges are not actively involved as mediators in SA compared to USA. In the South African High Court a judge may, with the consent of the parties and without any formal application, at a pre-trial conference or thereafter 'give any direction which might promote the effective conclusion of the matter.'⁴⁸² In terms of s 49 and 71 of the Children's Act⁴⁸³ a children's court may, in appropriate circumstances, refer a dispute to mediation. This means that in South Africa mediation is recognized in some areas of law. On the contrary, judicial mediation, is more established in the United States, is itself the subject of a wide and critical literature. As stated above, in the USA sitting judges act as mediators in programs which integrated part of the justice system, at every level and every area of law.⁴⁸⁴ Justice can be rendered through this model as it is comprehensive and unique in its longevity. In USA a settlement mainly brokered or actively mediated by a judge. The mediation techniques and strategies used by judges have increased the percentage of cases settled through mediation.⁴⁸⁵ Therefore, in USA there is increased promotion of the voluntary use ADR in resolving disputes.⁴⁸⁶

Additionally, in US the judges may select cases likely be settled by mediation, whereas in South Africa that obligation is relinquished to parties to decide?⁴⁸⁷ Rule 6 and 7⁴⁸⁸ provides that a dispute may be referred to mediation by

⁴⁸² Rule 37 Uniform Rules of Court: Rules Regulating the Conduct of the Proceedings of the Several Provincial and Local Divisions of the High Court of South Africa, in terms of the Supreme Court Act 59 of 1959.

⁴⁸³ Children's Act 38 of 2005

⁴⁸⁴ L Otisand EH Reiter 'Mediation by Judges: A New Phenomenon in the Transformation of Justice' (2006) 6 *Pepperdine Dispute Resolution Journal* at 351.

⁴⁸⁵ Marc Galanter "'... A Settlement Judge, Not a Trial Judge.'" Judicial Mediation in the United States' (1985) 12 *J of Law and Society* at 1; JA Wall and DE Rude 'Judicial Mediation: Techniques, Strategies, and Situational Effects' (1985) 41 *Journal of Social Issues* 47–63.

⁴⁸⁶ R Ingleby 'Court Sponsored Mediation: The Case Against Mandatory Participation' (1993) 56 *The Modern Law Review* 441–451.

⁴⁸⁷ ROSELLE op cit note.

⁴⁸⁸ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS Rule 6 and 7.

litigants after commencement of litigation but before judgment. However, akin to US in SA to certain extent judicial officials may force a party to use mediation if the case befits such a procedure. In addition, the dispute can be referred for mediation by the court, prior or during the trial but before judgment.⁴⁸⁹ This principle is derived from US jurisprudence, so is rule 5⁴⁹⁰ which requires referral to mediation prior to commencement of litigation.

In US it is mandatory for parties and attorneys to attend mediation process in all courts and attorneys spend more time talking in the negotiations than the parties themselves.⁴⁹¹ Furthermore, time spent in filing, referral and mediation is shorter hence time and costs are reduced for the parties.⁴⁹² Mediation study for US participants reveals that majority favour mediation than litigation hence there is greater involvement of parties in the resolution of the case.⁴⁹³ It is advisable for South Africa to reduce the costs incurred by parties in mediation by shortening filing and referral time and broaden facilitative standard of mediators.

In terms of rule 4⁴⁹⁴ the legal representatives are allowed and upon conclusion of the mediation settlement the dispute resolution officer must forward to the mediator and parties a copy to that effect. However, some commentators argue that despite the legal representation, one flaw of the rules bars advocates from attending court-based mediation.⁴⁹⁵ It is common cause in US and SA that disputants' legal rights should be promoted and defended during mediation process. It is submitted that during the mediation process the disputants' rights and interests needs to be defended for justice and mutual interests to be realized.

In South Africa, if settlement agreement is reached and was part of the litigation, it must be submitted to the judicial officer. However, where a settlement is

⁴⁸⁹ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS Rule 6 and 7.

⁴⁹⁰ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS.

⁴⁹¹ Op cite note.

⁴⁹² ROSELLE op cit note.

⁴⁹³ Ibid.

⁴⁹⁴ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES' COURTS

⁴⁹⁵ Joubert op cit note.

not reached, a report to that effect will be drafted?⁴⁹⁶ Local Rule 16.2 (f)⁴⁹⁷ requires the mediator to draft a report to the judge about the outcome of the mediation process within 7 days following the mediation conference.⁴⁹⁸ In addition, the approach adopted by US⁴⁹⁹ and subsequently by SA⁵⁰⁰ is that the arbitrary omission of mediation procedure means the costs also follow the event. It is submitted that this principle should be equally applied to medical negligence disputes. In the USA the adoption and implementation of such Local Rule enhanced the use of mediation as an ADR mechanism in civil disputes.⁵⁰¹ Florida Rules for Court–Appointed Mediators adopted and endorsed by the Florida Supreme Court have standards of ethics for professional mediators and procedures to ensure quality mediation.⁵⁰² In USA the benefits of mediation has spread to other fields of law of which medical negligence is not an exception.⁵⁰³ Therefore South Africa also needs to tap from such body of knowledge and construct standards of mediation in tackling medical negligence disputes. This can be done by establishing standards for mediators that is akin to the CCMA’s Code of Conduct for Commissioners in Annexure I.⁵⁰⁴

⁴⁹⁶ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES’ COURTS, Rule 10.

⁴⁹⁷ Local Rules United States District Court for the Southern District of Florida Revised 3 December 2012.

⁴⁹⁸ Local Rules United States District Court for the Southern District of Florida Revised 3 December 2012; The Florida Local Rule 16.2 (g) provides that if parties fail to reach a mutual settlement, the matter will be scheduled for trial

⁴⁹⁹ *Pelser v Levy* 1905 TS 466 469.

⁵⁰⁰ SOUTH AFRICAN COURT- ANNEXED MEDIATION RULES OF THE MAGISTRATES’ COURTS.

⁵⁰¹ Florida’s “Government in the Sunshine” Law, Florida Statutes Section 286.011, as incorporated into the Florida Government Cooperation Act, Florida Statutes Section 164.016, does not permit public entities to settle litigation against them without a public hearing preceded by due public notice. Public entities have therefore at times found themselves unable to comply with Local Rule 16.2.E. and have had to seek an exception from the rule in order to permit mediation. This amendment relaxes the requirement that parties be present with full authority to consummate a settlement where a public entity is a defendant, and provides instead that a representative be present who can negotiate.

settlement on the entity’s behalf and recommend settlement to the entity.

⁵⁰² In Re: Amendments to the Florida Rules of Appellate Procedure and the Florida Rules for Certified and Court-Appointed Mediators, Case No. SCO9-118, July 7, 1989.

⁵⁰³ SF Forehand ‘Helping the Medicine GO Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation’ (1999) 14:3 Ohio State Journal on Dispute Resolution.

⁵⁰⁴ Annexure I is an example of a model that can used to develop standards of conduct for mediators in medical negligence cases.

Mediation process: USA and SA

For mediation in the USA to reach settlement stage both parties ought to act in good faith at all material times to settle the claim.⁵⁰⁵ The procedure for mediation commences, with the mediator laying the house rules of mediation and this is followed by parties signing the mediation agreement.⁵⁰⁶

Confidentiality and Non-disclosure privilege

In SA mediation process requires confidentiality, neutrality, voluntariness and a settlement acceptable to all parties.⁵⁰⁷ With regard to confidentiality parties have to agree to the confidentiality and non-disclosure privilege of communicated information, and consequence of not adhering to such agreement.⁵⁰⁸ This will oblige parties to keep all information communicated between them confidential. Hence, confidentiality and non-disclosure privilege are essential principles of mediation process either in US and SA.

⁵⁰⁵ RL Harris and ME Rubin *Mediation: Better Resolution of Medical Malpractice Claims* (2003).

⁵⁰⁶ Ibid.

⁵⁰⁷ Rycroft A “Mediation of Human Rights Disputes” (1993) *de Rebus* 211.

⁵⁰⁸ Ibid.

Impartiality and neutrality

According to Rycroft the mediator must be impartial and neutral in assisting the disputants in reaching an acceptable settlement and should not expect to be compensated by the parties for conducting mediation process.⁵⁰⁹ This is supported by Mowatt who argues that mediator must embrace the task of discreet neutral assistance.⁵¹⁰ South Africa Commissioners for different bodies are statutorily obliged to be impartial in mediation, and subject only to the Constitution and law.⁵¹¹ Rycroft also argues that an imposed mediator may not be seen as impartial by the disputants.⁵¹²

Voluntariness

Voluntariness is one of the essential principles of mediation process.⁵¹³ The process ideally must be voluntary from the beginning to the end of the process. As a result the consent of the parties is prerequisite throughout the process. Voluntariness is a well-established norm in South African mediation. In *Inwood International Co v Wal-Mart Stores*⁵¹⁴ the US courts stated that one is presumed to have the authority to consent to mediate when one is present at the mediation. It was also stated that confirmatory proof to the contrary may be required to prove reverse such a presumption. However, the principal is still bound by the acts of its agent in mediation.⁵¹⁵

Mediator's role

It is not the duty of the mediator to ensure that fair and just settlement mediation is successful this differs in divorce mediation where the mediator's function is to empower the weaker party and ensure that the best interests of the children are protected.⁵¹⁶ It is argued that, if it is outside the scope of mediator there

⁵⁰⁹ A Rycroft 'Mediation of Human Rights Disputes' (1993) *de Rebus* 211.

⁵¹⁰ JG Mowatt 'Some Thoughts on Mediation' (1988) 105 *The South African Journal* at 727.

⁵¹¹ Rycroft op cit note at 289; Boule and Rycroft op cit note.

⁵¹² Ibid.

⁵¹³ However, it should be noted that that CCMA conciliation is not voluntary and it does not appear to impact on the outcome.

⁵¹⁴ *Inwood International Co v Wal-Mart Stores* 243 F 3d 567 (CA Fed 2000).

⁵¹⁵ *Castillo v. Case Farms of Ohio*, 96 F Supp. 2d 578.

⁵¹⁶ Mowatt op cit note.

are limits that can compel mediator to withdraw from an unconscionable settlement.⁵¹⁷ It is submitted therefore that non-directive mediator type should be applied also in medical negligence. However, the inequality between disputants plays an essential role in mediation process.⁵¹⁸ Conversely, in complex cases mediation is better performed by co-mediators.⁵¹⁹ Multiparty mediation can also take place, if there are more than two parties involved.⁵²⁰ This applies well in medical negligence cases where the patient was referred to different medical practitioners. In South Africa poor disputants may be forced to settle unfavourable, because they cannot afford the litigation costs.⁵²¹

Termination of the mediation process

Parties are at liberty to terminate the mediation process prior to conclusion of the agreement.⁵²² Information divulged through mediation will be without prejudice and any party cannot be held liable for what was said during mediation.⁵²³

Caucuses

In US medical malpractice mediation, lawyers or client can narrate the story, every party is given the opportunity to outline his or her version.⁵²⁴ Whenever there is an impasse parties are divided into caucuses, in which the mediator will discuss with each party in privacy.⁵²⁵ Parties will disclose their positions and interest to the mediator and negotiation will be based upon interest and not positions. The mediation for malpractice ought to be designed to cater for extra-judicial concerns.⁵²⁶ It is submitted that in the mediation of multifaceted medical negligence disputes caucuses will be essential to adopt.

⁵¹⁷ Rycroft op cit note.

⁵¹⁸ Mowatt op cit note.).

⁵¹⁹ Ordovery A.P, et al *Alternatives to Litigation: Mediation Arbitration and the Art of Dispute Resolution* (1993) *NITA* at 93.

⁵²⁰ *Ibid* at 94.

⁵²¹ Mowatt op cit note.

⁵²² L Boule and A Rycroft *Mediation; Principles Process Practice* (1996).

⁵²³ *Ibid* at 328.

⁵²⁴ RL Harris and ME Rubin *Mediation: Better Resolution of Medical Malpractice Claims* (2003).

⁵²⁵ Harris and Rubin op cit note.

⁵²⁶ CB LIEBMAN and CS CHRIS STERN HYMAN *MEDICAL ERROR DISCLOSURE, MEDIATION AND MALPRACTICE LITIGATION: A DEMONSTRATION PROJECT IN*

Settlement Agreement

In any mediation, the process concludes with a settlement between the parties.⁵²⁷ As a standard of mediation, the attorney ought to have the consent of the party before signing the settlement agreement.⁵²⁸ As mentioned earlier in South Africa the enforcement of mediated settlement agreements is not problematic for the courts. South African law considers a contract as valid if there is consensus between the contracting parties.⁵²⁹ In *Stocks and Stocks (Cape) Pty Ltd v Gordon and Others*⁵³⁰ the South African courts considered mediation agreements. It was stated that there was need for the judicial to respect the mediation agreement as ADR mechanisms were provided for pending arbitration. However, the same cannot be said of US mediated agreements, due to increase in the usage of mediation, mediation agreement conflicts have resulted in a substantial body of judge-made law.⁵³¹ With fifty states and federal jurisdiction there are different laws governing the implementation of mediation agreements.⁵³² However, states like Florida and Texas allows for the enforceability of any signed written settlement agreement. Florida State has even a provision of ‘cooling off’ period in which the consent can be withdrawn.⁵³³ A settlement agreement signed by an attorney can be held as valid if express authority was given or existed and the other party has no reason to doubt the existence of that authority.⁵³⁴ In *Georgos v Jackson*⁵³⁵ it was stated that situations

PENNSYLVANIA, available at http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Medical_liability/LiebmanReport.pdf (noting that the evaluative model predominates for handling such disputes), [accessed on 09 July 2013].

⁵²⁷ Boulle and Rycroft op cit note.

⁵²⁸ Ibid.

⁵²⁹ J Du Plessis et al; *The Law of Contract in South Africa*: Oxford University Press, (2010); *MEC for Economic Affairs, Environment and Tourism, Eastern Cape v Kruizenga* 2008 6 SA 264 (Ck) *MEC for Economic Affairs, Environment and Tourism, Eastern Cape v Kruizenga* 2010 4 SA 122 (SCA) [2011] DEJURE 13.

⁵³⁰ *Stocks and Stocks (Cape) Pty Ltd v Gordon and Others*, NNO 1993 (1) SA 156 (T).

⁵³¹ E Sussman ‘A Brief survey of US Case Law on Enforcing Mediation settlement Agreements over Objections to the existence or validity of such Agreements and Implications for Mediation Confidentiality and Mediator testimony’ (2006) IBA Legal Practice Division, *Mediation Committee Newsletter*.

⁵³² P Robison ‘Centuries of Contract Common Law Can’t be All Wrong: Why the UM’s exception to Mediation Confidentiality in Enforcement Proceedings should be embraced and Broadened’ (2003) *J Disp Resol*.

⁵³³ LOCAL RULES United States District Court for the Southern District of Florida Revised December (2011).

⁵³⁴ *Little v Greyhound Lines Inc* 2005 WL 2429437 (SDNY 2005).

where the party's absence was not justified at mediation, even where state legislations requires a signature of the party concerned, courts have endorsed the validity of mediation settlement agreement notwithstanding the absence of supposed signature.

Models of Mediation in US and SA

In South Africa there are different models used as guidelines for mediation. For instance, *settlement mediation* encourages parties to compromise their positions towards a settlement. This requires persuasive skills by the mediator to break the impasse.⁵³⁶ Secondly, *facilitative mediation* emphasizes the parties' interests and needs than parties' positions and legal rights.⁵³⁷ Therefore it is the mediator's obligation to enhance productive dialogue between the parties during the negotiation process. Thirdly, *therapeutic mediation* is another model which aims to tackle the underlying issues of the dispute.⁵³⁸ In USA it is described as the "narrative model" which is based upon the need to solve the problem, by use of deconstruction and use of alternative narratives to heal the relationship of parties and find a solution.⁵³⁹ It is argued that all these models conflict should be defined based on interest and not positions.⁵⁴⁰ Hence, under this model the mediator has to utilise therapeutic skills to facilitate a mutually acceptable resolution. Such a model has been derived from USA in its unfettered form. Lastly, *evaluative mediation* requires legal rights and entitlements to be considered against the background of the projected litigation outcome.⁵⁴¹ On the other hand, in US *pragmatic model* is characterized by two approaches to negotiation; adversarial and cooperative.⁵⁴² However, this method if adopted affects the relationship between parties, manner of negotiation and its eventual outcome.⁵⁴³ Adversarial approach may be used to show dominance and

⁵³⁵ *Georgos v Jackson* 790 NE 2d448 (Ind 2003).

⁵³⁶ Rycroft op cit note at 294

⁵³⁷ Ibid.

⁵³⁸ Rycroft op cit note at 294.

⁵³⁹ M Alberstein 'Forms of Mediation and Law: Cultures of Dispute Resolution' (2007) 22:2 *OHIO STATE JOURNAL ON DISPUTE RESOLUTION*.

⁵⁴⁰ Fisher and Ury *op cit note*.

⁵⁴¹ Rycroft op cit note.

⁵⁴² Alberstein op cit note.

⁵⁴³ C Thomas *THE STRATEGY OF CONFLICT* (1960).

designed to maximize one's shares and minimize losses.⁵⁴⁴ It is submitted that in medical negligence disputes, the use of a pragmatic cooperative approach is more supportive of opportune negotiated settlement. Nevertheless, parties to the conflict should shift from competitive to cooperative approach in negotiation.⁵⁴⁵

In conclusion, in some models of mediation mainly evaluative mediation, it is the role of the mediator to provide specialized advice and information to the parties.⁵⁴⁶ It is submitted that for medical negligence disputes the mediation model applicable would be mixture of facilitative, evaluative and therapeutic mediation. The dissertation agrees with the position adopted by Rycroft that mediation can be applicable where human rights are violated.⁵⁴⁷ Hence the violation of right to bodily integrity and human dignity through medical negligence can be resolved by mediation. The idea of court annexed mediation ought to be allowed to be ripe in the minds of South Africans to gain momentum beginning with lower courts to higher courts.⁵⁴⁸ It is time to abandon the old accusatorial system and adopt alternative dispute resolution mechanisms, which allows justice to be attained, even for the ordinary person.⁵⁴⁹ The role of the mediator would be to empower the parties and encourage multicultural interaction between parties.⁵⁵⁰ This can be achieved by managerial skills of confining parties to focus on the interests than the positions.⁵⁵¹ SA having adopted by and large USA jurisprudence on mediation, mediators should be at least knowledgeable in disciplines concerned to facilitate the mediation process effectively. Mediation of medical negligence results in the patients receiving compensation sooner and public hospitals saving litigation costs. Furthermore, it

⁵⁴⁴ P Young *NEGOTIATION ANALYSIS* (1999).

⁵⁴⁵ Fisher and Ury op cit note.

⁵⁴⁶ Rycroft op cit note.

⁵⁴⁷ Rycroft op cit note.

⁵⁴⁸ D Scott-Macnab 'Mediation – The Procedure of the Future' (1989) *de Rebus* 211; D Scot 'MEDIATION IN THE FAMILY CONTEXT' (1988) 105 *The South African Law Journal*.

⁵⁴⁹ Scott-Macnab *Dop* cit note.

⁵⁵⁰ Alberstein op cit note.

⁵⁵¹ *Ibid*.

spares patients and medical practitioners of experiencing the brutal and emotionally draining discovery process in litigation.⁵⁵²

University of Cape Town

⁵⁵² CB LIEBMAN 'Medical Malpractice Mediation: Benefits Gained, Opportunities Lost' (2011) 74 *Law and Contemporary Problems*.

CHAPTER 6: CONCLUDING OVERVIEW

This chapter provides a supposition in which a summary is given to the dissertation. The primary aim of this dissertation was to discover how to tackle the increase in medical negligence litigation by the use of ADR mechanisms in the South African legal system. It should be noted that the period and data considered in this dissertation were limited to the information available. In spite of the limitation in data, the data secured is indicative of the level of medical negligence vis-à-vis litigation claims in public hospitals across seven selected provinces of South Africa.⁵⁵³ To better comprehend the magnitude of increase medical negligence lawsuits, tables and graphs were used to illustrate the millions of rands being paid as compensation and the average of 3 years is required for finality to be given to a case by the courts.

The dissertation considered the period between 2008 and 2009 for seven provinces which are Mpumalanga, Gauteng, Western Cape, Northern Cape, North West, Free State and Eastern Cape. The graph for the provinces shows an upward trend for medical negligence claims in public hospitals. The claims instituted in 2012 for Gauteng province are indicative of the “microcosm of the macrocosm” of an inevitable impending public hospitals catastrophe. The dissertation has exposed various factors that have been contributing to the increase in medical negligence in public hospitals. Thus, the shortage of medical practitioners and medical services is one of the significant factors. In that the shortage of skilled medical practitioners results in the few available carrying an overload of work and whose capacity will be severely affected by fatigue and diminished concentration. In addition, shortage of equipment in most rural hospitals, as well as contingency and public awareness of patients’ rights has contributed to the increase in medical negligence.

The analysis of selected court cases has revealed that cases between 2003 and 2013 took an average time spent of 3 years to be completed. The slow pace in resolving disputes has resulted in a backlog of medical negligence lawsuits, which benefits the legal practitioners and not the medical practitioners. Due to such a

⁵⁵³ Source: E Naidoo *ibid*.

bottleneck, the emphasis of the thesis has been centered on the potential use of ADR mechanisms such as arbitration and mediation in resolving medical negligence cases.

Medical negligence of doctors in public hospitals fails to measure according to the test of a reasonable doctor in the same circumstances. It is the position of the dissertation that the medical practitioners are bestowed with the duty of care to their patients, as medical negligence is conceptually the same as the negligence test in general. It is evident that public hospitals are vicariously held liable for the conduct of their medical practitioners. It has been determined from the analyzed court cases that misdiagnosis, anesthesia errors, incompetence of staff and shortage of equipment have contributed to medical negligence cases contested in courts.

Findings

The focus of this dissertation is how medical negligence disputes can be resolved by the potential use of ADR mechanisms in South Africa. It was found that ADR mechanisms should be used for their advantageous characteristics as cheap and speedy settling conflicts. Litigation has failed in handling a myriad of medical negligence cases. Negotiation has potential to be effective, if used outside adversarial setting. Arbitration is one of the ADR mechanisms in which parties reach a settlement through a binding decision of a third party. It is quick and parties have control over the nature of the proceedings. However, it was noted that it can come to equal costs as litigation, if parties agree on documentary evidence and oral evidence in the arbitral proceedings.

Under ADR mechanisms, the use of mediation is more favorable in resolving medical negligence cases, in that the ongoing doctor-patient relationship will be protected, because the patient needs the doctor and such encourages respect and cooperative association. It was also noted that mediation use in medical negligence disputes results in speedy and less costly settlement being reached. Henceforth, it saves time that is spent in litigation and avoids postponement and emotional strain experienced by parties in litigation. Parties can negotiate for a mutually beneficial settlement compared to litigation in which a third party decides the fate. It is the position of this dissertation that court annexed mediation should be extended to High Courts, to cover the claims in medical negligence, since magistrate courts' scope is limited by monetary jurisdiction.

Mediation can be made effective in resolving medical negligence, if parties have a say in the appointment of a mediator. It allows parties to develop mutual respect and cooperation. For mediation to work, both parties should adopt rather interest based than adversarial strategies, which focus on positions. As a result, the dissertation uncovers that mediation can be a viable option to tackle medical negligence cases in South Africa. This was done by comparing court-annexed model used in tackling medical negligence in the USA to the South African proposed model. South Africa has relied significantly upon the USA mediation system. Although ADR is rooted in USA, it is upon the South African judicial system to be legally innovative in transforming that which was borrowed to suit South African legal environment based on its historical context. Mediation is different from the adjudication system in that in mediation, decisions are made by parties and are not binding. It was found that mandatory mediation will result in few medical negligence cases being referred to litigation.

Recommendations

Mediation Panel Composition

It is the recommendation of this dissertation that due to the complexity that characterize medical negligence cases. The panel should be composed of a person or persons knowledgeable in the field. Hence, the mediator ought to have at least knowledge about the field so as to be able to facilitate the mediation process in a credible manner. The mediator can on the alternative be constituted of a medical advisor, interpreter and legal advisor. This will allow effectiveness to be given to the process and satisfaction derived by both disputants.

Independent body

An independent body should be established and to evaluate based on specified medical and legal standard, medical negligence cases that qualify for litigation and those that are suitable for mediations. If mediation is mandatory in civil disputes, the public hospitals will escape costs order, if the other party resorts to litigation vis-à-vis its proposition for mediation, especially cases where the facts speak for themselves. Hence, the creation of an Ombudsman under public hospitals, specifically for medical negligence cases, will make litigation avoidance a norm.

Introduction of cap system for the cost of negligence

In addition, it is the recommendation of this dissertation that the health department should introduce the capping for the cost of medical negligence. This will discourage the legal practitioners who have made this a lucrative field based only on cases which they considered winnable. Capping will allow the poor also to claim for compensation through the use of mediation based legal system. This cap system will limit maximum payout experienced in medical negligence claims nationwide. In cases where the sum reached the maximum stipulated capped amount. The capping system can be corresponded by compensating the victims through the use installments system compared to payment of lump sums.

Training of mediators

The mediators that should be used to facilitate medical negligence cases should be trained. This means medical practitioners and legal practitioners need to be trained specifically for such disputes. In addition, mediation in medical negligence should be sensitive to ethnicity and diversity that characterize South African culture. Interpreters should be used to enhance effective communication, because language can be a barrier for effective mediation in medical negligence. These mediators should be certified and registered with a reputable institution⁵⁵⁴ to avoid unscrupulous practice. This institution should be able to monitor and enhance quality assurance for mediators, through examination, on general mediation knowledge and techniques.

IT and Mediation

In this technologically defined society, Information Technology (IT) ought to be linked to mediation. For parties in different locations, the use of chat room and teleconference should be encouraged and adopted. In addition, the use of electronic mediation roll should be adopted to speed up the mediation process in medical negligence cases.

Syllabus change for medical students

In my finding with University of Cape Town, Medical school syllabus, it can be noted that universities' syllabi do not expose medical students to medical

⁵⁵⁴ For example South African Mediation Institute.

negligence law and cases from a legal perspective. Hence, formal education in medical field does not comprehensively prepare doctors for the moral challenges in the medical profession. It is recommended that final year medical students should be exposed to the law of medical negligence and the consequences thereof. Knowledge of negligence will enable the doctors to make and exercise conscious duty of care in public hospitals. If students are exposed to such before they are released into public hospitals their consciousness of the legal consequences will impose a duty of care to prevent against medical negligence. It is recommended that a course on law and medical negligence should be constructed and made as a compulsory in the ethics module, for final medical students prior to their induction into practice.

University of Cape Town

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ANNEXURE I

Code of Conduct for Commissioners

This code is developed in terms of Section 117 of the Labour Relations Act No 66 of 1995.

PURPOSE

1. The purpose of this code is to:
 - 1.1 assist in maintaining the good repute of the conciliation, mediation and arbitration processes and in particular the office of the CCMA.
 - 1.2 Provide guidance to all commissioners on matters of professional conduct and practice generally.

GENERAL ATTRIBUTES OF COMMISSIONERS

2. In order for conciliation, mediation and arbitration processes to be seen to be fair and just and gain the confidence of the public, commissioners shall:
 - 2.1 act with honesty, impartially, due diligence and independent of any outside pressure in the discharge of their statutory functions.
 - 2.2 conduct themselves in a manner that is fair to all parties and shall not be swayed by fear of criticism or by self interest.
 - 2.3 not solicit appointment for themselves. This shall not however preclude commissioners from indicating a willingness to serve in any capacity.
 - 2.4 accept appointments only if they believe that they are available to conduct the process promptly and are competent to undertake the assignment.
 - 2.5 avoid entering into any financial, business or social relationship, which is likely to affect their impartiality, or which might reasonably create a perception of partiality or bias.
 - 2.6 not influence CCMA officials or employees by improper means, including gifts or other inducements.

CONFLICT OF INTEREST AND DISCLOSURE

3. Commissioners should disclose any interest or relationship that is likely to affect their impartiality or which might create a perception of partiality. The duty to disclose rests on the commissioners.
4. Commissioners appointed to intervene in any matter should, before accepting disclose directly to the CCMA or through their accredited agents:
 - 4.1 Any direct financial or personal interest in the matter.
 - 4.2 Any existing or past financial, business, professional, family or social relationship which is likely to affect impartiality or may lead to a reasonable perception of partiality or bias.
 - 4.3 If the circumstances requiring disclosure are unknown to commissioners prior to accepting appointments, disclosure must be made when the commissioners know such circumstances, The disclosure in this regard could in arbitration proceedings, include witnesses who may have relationship with the commissioners.
 - 4.4 After appropriate disclosure commissioners may serve if both parties so desire but should withdraw if they believe that a conflict of interest exists irrespective of the view expressed by the parties.
 - 4.5 In the event where there is no consensus on whether conciliators and arbitrators should withdraw or not, commissioners should not withdraw if the following circumstances exist:
 - 4.5.1 If the terms of reference provide for a procedure to be followed for determining challenges to the conciliators and arbitrators, then those procedures should be followed.
 - 4.5.2 If commissioners, after carefully considering the matter, determine that the reason for the challenge is not substantial and that they can nevertheless act impartially and fairly, and that the withdrawal would cause unfair delay or would be contrary to the ends of justice.

HEARING CONDUCT

5. Commissioners should conduct proceedings fairly, diligently and in an even-handed manner.
6. Commissioners should have no casual contact with any of the parties or their representatives while handling a matter without the presence or consent of the other.

7. Commissioners should be patient and courteous to the parties and their representatives or witnesses and should encourage similar behaviour by all participants in the proceedings.
8. Arbitrators should respect agreements by the parties for the use of mechanical recording.
9. In determining whether to conduct an ex parte hearing, an arbitrator must consider the relevant legal, contractual and other pertinent circumstances.
10. A commissioner must be satisfied before proceeding ex parte that a party refusing or failing to attend the hearing has been given adequate notice of time, place and purpose of the hearing.
11. In an event of more than one commissioner acting either as a conciliator, mediator or arbitrator, the commissioner should afford each other a full opportunity to participate in the proceedings.
12. Commissioners should not delegate their duty to intervene in any matter to any other person without prior notice to and the consent of the CCMA.

POST HEARING

13. Commissioners should not disclose a prospective award to either party prior to its simultaneous issuance to both parties.
14. Commissioners' awards should be definite, certain and as concise as possible.
15. No clarification or interpretation of an award is permissible without the consent of both parties.
16. Under agreements, which permit or require clarification or interpretation of an award, arbitrators shall afford each party an opportunity to be heard.

CONFIDENTIALITY

17. Information disclosed to commissioners in confidence by a party during the course of conciliation, should be kept by commissioners in the strictest confidence and should not be disclosed to the other party or to third parties unless authority is obtained for such disclosure.

JURISDICTION

18. Commissioners must observe faithfully both the limitation and inclusions of the jurisdiction conferred by an agreement or by statute under which they serve.
19. A direct settlement by the parties of some or all issues in a case, at any stage of the proceedings, must be accepted by commissioners as relieving him or her of further jurisdiction in respect of such issues.

RELIANCE ON OTHER ARBITRATORS' AWARDS AND INDEPENDENT RESEARCH

21. Commissioners issuing advisory or binding awards may have regard to other arbitrator's awards, decided cases or independent research but must assume full and unimpaired responsibility in each matter for the decision reached.

AVOIDANCE OF DELAYS

22. Commissioners have the duty to plan their work schedules in a manner that ensures that commitments to the CCMA are fulfilled timeously.
23. Commissioners should cooperate with the parties and the CCMA to avoid delays.
24. On completion of a hearing, commissioners shall submit an award within 14 days.

FEES AND EXPENSES

25. Part-time Commissioners acting as such should be governed by the fee structure of the CCMA and should not enter into any arrangement with the parties regarding fees.
26. Commissioners must maintain adequate records to support charges for services and expenses and must account timeously to the CCMA.

COMPETENCE

27. Commissioners should decline appointment, withdraw or request technical assistance when they decide that a matter is beyond their competence.
28. Commissioners acting as conciliators should understand the issues which form part of the dispute before endeavouring to assist the parties with the settlement of that dispute. In this regard, commissioners should spend time at the beginning of the proceedings to make sure that they understand the positions, the needs and expectations of the parties.

BASIS OF CONCILIATION PROCEEDINGS

29. Commissioners acting as conciliators should determine at the commencement of a matter whether the proceedings will take place on a “without prejudice” basis and should secure the agreement of the parties in this regard.

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